

Assessments of sexual, reproductive, maternal, newborn, child and adolescent health in the context of universal health coverage in six countries in the WHO European Region

A synthesis of findings from the country reports

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Abstract

Achieving universal health coverage (UHC) – meaning that everyone, everywhere can access essential high-quality health services without facing financial hardship – is a key target of the Sustainable Development Goals. Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) is at the core of the UHC agenda and is among the 16 essential health services that WHO uses as indicators of the level and equity of coverage in countries. In this context, WHO undertook an assessment of SRMNCAH in six countries (Albania, Azerbaijan, Kazakhstan, Kyrgyzstan, the Republic of Moldova and Romania) in the WHO European Region. This report summarizes health system barriers to UHC for SRMNCAH, including from a gender and rights perspective. By pointing to three major challenges and making related policy recommendations, it highlights specific issues around SRMNCAH. The challenges and recommendations cut across different aspects of the health systems and involve other sectors. The problems encountered are thus likely to affect the system beyond the scope of this assessment, making it a marker of the overall health system functions. The recommendations are intended to contribute to efforts in accelerating progress towards UHC.

Keywords

SEXUAL AND REPRODUCTIVE HEALTH
MATERNAL, CHILD AND ADOLESCENT HEALTH
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HEALTH CARE SYSTEM
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Abbreviations

EU	European Union
GDP	gross domestic product
HPV	human papillomavirus
IMCI	Integrated management of childhood illnesses [WHO strategy]
IUD	intra-uterine device
NGO	non-governmental organization
OECD	Organisation for Economic Co-operation and Development
OOP	out-of-pocket [payment]
PHC	primary health care
SDG	sustainable development goal
SRMNCAH	sexual, reproductive, maternal, newborn, child and adolescent health
STI	sexually transmitted infection
UHC	universal health coverage
UNICEF	United Nations Children's Fund

Executive summary

Introduction

Achieving universal health coverage (UHC) is one of the targets the nations of the world set when adopting the Sustainable Development Goals in 2015. UHC means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) is at the core of the UHC agenda, which cannot be achieved without a strong focus on these services. On this basis, an assessment was undertaken in six countries (Albania, Azerbaijan, Kazakhstan, Kyrgyzstan, the Republic of Moldova and Romania) in the WHO European Region to:

- delineate which SRMNCAH services are included in policies concerning UHC;
- assess the extent to which they are available to the people for whom they are intended and at what cost;
- identify potential health system barriers to the provision of SRMNCAH services, using a tracer methodology and equity lens;
- identify priority areas for action and develop policy recommendations.

Methodology

The assessments were a joint effort between WHO and the countries, with the full involvement of the WHO country offices. They involved a document review followed by a country visit, which included interviews based on semi-structured questionnaires with policy-makers, representatives of the government and health insurance fund, health facility managers, doctors, midwives, nurses, patients, clients and partners. Health care facilities at the primary, secondary and tertiary levels were visited. Findings and recommendations were presented and discussed with key stakeholders in each country.

To assess the extent to which services were available to the people for whom they were intended and at what cost, six “tracer interventions” were used to analyse health system performance in depth. These were

- antenatal care, with a focus on pre-eclampsia;
- sexually transmitted infections (STIs, excluding HIV);
- transport of sick neonates;
- case management of common childhood conditions, with a focus on pneumonia;
- adolescent-friendly health services, with a focus on sexual and reproductive health;
- immunization.

The tracer interventions were selected to cover the continuum of care, as well as cross-cutting health system issues.

Findings

Findings in relation to the tracer interventions showed that antenatal care and immunization perform relatively better than the others in all the countries assessed. Sexual and reproductive health services for adolescents, transport of sick neonates and STIs score more poorly, while management of common childhood conditions shows a mixed picture. Common to the first two tracers is that they are less controversial and can be provided on a scheduled basis. Transport of sick neonates requires capacity and skills at primary, secondary and tertiary

levels, as well as a well functioning referral system. Adolescent sexual and reproductive health services and treatment of STIs are affected by societal values and health workers' attitudes.

Looking at the assessment areas of protocols, scope of services, coverage and quality of services, the last is the greatest challenge for most of the tracer interventions.

The assessments identified three major challenges that need to be addressed to achieve UHC in the area of SRMNCAH:

- improvement of primary health care for SRMNCAH;
- adequate health benefit packages in relation to SRMNCAH;
- specific SRMNCAH areas and interventions needing more attention.

Improvement of primary health care for SRMNCAH

All the countries have a system of family doctors at the primary health care (PHC) level who should function as a one-stop shop and provide a gatekeeping function to higher levels of care. Family doctors are not always skilled or provided with the facilities to deliver essential services, however, causing referrals and fragmentation. In some countries, paediatricians and obstetricians also work at the PHC level, but the services are not fully integrated. The roles of nurses and midwives are not clearly defined in the PHC context and their work may be underutilized to expand, enhance and coordinate the reach of PHC services.

Polypharmacy and overuse of antibiotics are common problems in most countries; overhospitalization of cases that could be safely managed as outpatient is also extensive. The PHC level is often bypassed and patients go directly to hospitals or private providers. This is partly caused by poor organization of care at the PHC level, where it can take multiple visits to get a diagnosis or resolve an episode of ill health. Furthermore, sometimes financial incentives are in place for hospital admission – for both patients and providers – and the PHC level is often not sufficiently equipped or incentivized to expand services. Recruitment and retention of health workers in rural areas are seen as a challenge in all countries. The main reasons reported are low salaries and poor working conditions.

Adequate health benefit packages in relation to SRMNCAH

Government expenditure on health ranges between 1% and 4% of gross domestic product in the assessed countries – well below the European Union average of 7%. It is not possible to track expenditures for specific SRMNCAH services, however, and official co-payment policies vary from country to country. Out-of-pocket (OOP) payments are moderate to high in all countries, varying from 21% to 79% of health expenditure, and to a large extent driven by OOP payments on medicines. Informal and formal co-payments for services such as ultrasound and laboratory investigations were reported by key informants in several countries.

None of the countries have clear and defined criteria for deciding which services are included in the health benefit packages or subsidized. Nominally, the official benefit packages are often “all-inclusive” for emergency care, PHC and maternal and child health, covering a wide range of services and – with few exceptions – the entire population. This is also the case in countries with mandatory health insurance where population coverage does not reach 100%. The service packages are, however, often underfunded, leading to rationing or informal payments in practice. In addition, financing mechanisms at times provide incentives for overutilization of hospital care for both patients and providers.

Specific SRMNCAH areas and interventions needing more attention

Two areas were highlighted in particular as needing great focus: sexual and reproductive health, which is not addressed in a comprehensive manner; and neonatal health, which needs greater attention.

Sexual and reproductive health is still controversial in many countries and only two of the assessed countries have a specific strategy in place. Only one country provides sexuality education in schools. Protocols and legislation in some countries preclude adolescents under 18 years of age accessing services without parental consent; in other countries, the legislation on provision of sexual and reproductive health services to adolescents is inconsistent. Where the legislation allows younger adolescents to access services, health workers are not always aware of it or do not follow it. Adolescent sexual and reproductive health services are nonexistent or very limited in most countries and large-scale adolescent-friendly health centres are established only in one country. Contraceptives and human papillomavirus vaccination are not included in the health benefit packages. Abortion services are also not included, except for miscarriage or for a medical reason.

Protocols and standards for transport of sick neonates that include personnel, medical care during transport, equipment and transport administration are often not in place. Medical staff transporting sick neonates are often not specifically trained. Neonates often arrive following long delays, with hypothermia and in a poor condition. Families experience OOP payments – often informal – and needed to make private arrangements to transport sick neonates to higher-level facilities.

Conclusion

This report summarizes health system barriers to UHC for SRMNCAH, including from a gender and rights perspective. By pointing to three major challenges and making related policy recommendations, it highlights specific issues around SRMNCAH.

The challenges and recommendations cut across different aspects of the health systems and involve other sectors. The problems encountered are thus likely to affect the system beyond the scope of this assessment, making it a marker of the overall health system functions. The recommendations are intended to contribute to efforts in accelerating progress towards UHC.

Introduction

Achieving universal health coverage (UHC) is one of the targets the nations of the world set when adopting the Sustainable Development Goals in 2015. UHC means that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship. This definition of UHC embodies three related objectives:

- equity in access to health services – everyone who needs services should get them, not only those who can pay for them;
- quality of health services – they should be good enough to improve the health of those receiving them;
- protection from financial risk – ensuring that the cost of using services does not put people at risk of financial harm.¹

Sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) is core to the UHC agenda and is among the 16 essential health services in four categories that WHO uses as indicators of the level and equity of coverage in countries. Essential SRMNCAH services used as indicators for UHC are:

- family planning
- antenatal and delivery care
- full child immunization
- health-seeking behaviour for pneumonia.

The essential services core to the UHC agenda are broader than those captured by the indicators. The Guttacher–Lancet Commission² proposes an essential package of sexual and reproductive health interventions that includes:

- comprehensive sexuality education;
- counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods;
- antenatal, childbirth and postnatal care, including emergency obstetric and newborn care;
- safe abortion services and treatment of complications of unsafe abortion;
- prevention and treatment of HIV and other sexually transmitted infections (STIs);
- prevention, detection, immediate services and referrals for cases of sexual and gender-based violence;
- prevention, detection and management of reproductive cancers, especially cervical cancer;
- information, counselling and services for subfertility and infertility;
- information, counselling and services for sexual health and well-being.

The WHO European Region is guided by several key strategies, action plans and policy documents in the field of SRMNCAH. Action Plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable

¹ What is health financing for universal coverage? In: World Health Organization [website]. Geneva: World Health Organization; 2019 (https://www.who.int/health_financing/universal_coverage_definition/en/, accessed 18 November 2019).

² Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R et al. Accelerate progress – sexual and reproductive health and rights for all: report of the Guttacher–Lancet Commission. *Lancet*. 2018;391(10140):2642–92. doi:10.1016/S0140-6736(18)30293-9.

Development in Europe – leaving no one behind³ provides a comprehensive framework that addresses sexual and reproductive health. It needs to be adapted at the national level, in line with the international commitments that Member States have already made. Investing in children: the European child and adolescent health strategy 2015–2020⁴ aims to enable children and adolescents in the WHO European Region to realize their full potential for health, development and well-being, and reduce their burden of avoidable disease and mortality. It recommends adopting a life-course approach that recognizes that adult health and illness are rooted in health and experiences in previous stages of the life-course.

In adopting the 2030 Agenda and the Sustainable Development Goals (SDGs), governments have made it clear that all goals are interconnected and indivisible. They have further reaffirmed human rights, gender equality and women’s empowerment as being crucial to progress on all goals and targets. Therefore, any assessment relating to UHC and SRMNCAH under SDG 3 on ensuring healthy lives and promote well-being for all at all ages needs also to consider targets and goals under SDG 5, for a more complete analysis of barriers and achievements. In particular, SDG 5.2 on eliminating all forms of violence against women and girls; SDG 5.3 on eliminating all harmful practices, such as child, early and forced marriage and female genital mutilation; and SDG 5.6 on ensuring universal access to sexual and reproductive health and reproductive rights. As sexual and reproductive health is closely connected with social and gender norms and political contexts, it has to be tackled through multisectoral approaches, including analysis, interventions and monitoring. Therefore, SDG 4 on education and SDG 10 on reducing inequalities are also particularly relevant.

Within this framework, assessments of SRMNCAH in the context of UHC were done in six countries (Albania, Azerbaijan, Kazakhstan, Kyrgyzstan, the Republic of Moldova and Romania) in the WHO European Region during September 2018–February 2019. The specific objectives of the assessments were to:

- delineate which SRMNCAH services are included in policies concerning UHC in the specific country context;
- assess the extent to which the services are available to the people for whom they are intended, and at what cost;
- identify potential health system barriers to the provision of SRMNCAH services, using a tracer methodology and equity lens;
- highlight good practices and innovations in the health system, with evidence of their impact on SRMNCAH services;
- identify priority areas for action and develop policy recommendations jointly with the country to address health system barriers to the provision of SRMNCAH services.

The assessments were done in collaboration with the national ministries of health and led by the WHO country offices, in collaboration with the WHO Regional Office for Europe. A report was created for each assessment; it was then discussed and presented to the ministry of health and key partners in the country for comments and corrections of any errors or misunderstandings to ensure that the factual content was accurate.

The purpose of this synthesis report is to:

- summarize findings from the six country assessments;

³ Action Plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind. Copenhagen: WHO Regional Office for Europe; 2016 (<http://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health/publications/2016/action-plan-for-sexual-and-reproductive-health-towards-achieving-the-2030-agenda-for-sustainable-development-in-europe-leaving-no-one-behind-2016>, accessed 18 November 2019).

⁴ Investing in children: the European child and adolescent health strategy 2015–2020. Copenhagen: WHO Regional Office for Europe; 2014 (<http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/policy/investing-in-children-the-european-child-and-adolescent-health-strategy-20152020>, accessed 18 November 2019).

- identify health systems barriers to UHC for SRMNCAH, including from a gender and rights perspective, and extrapolate them to wider health systems issues;
- highlight examples of good practice;
- identify and make recommendations on areas targeted for priority action in the WHO European Region.

The summary of findings is not a comparison of the countries assessed. This is not the aim; nor would it be possible, as the appraisal of the findings was done by different assessment teams and based on the information obtained as described in the section on the limitations of the report. This summary rather aims to detect common trends and differences, as well as examples of good practice; these can be used as background to identify areas for priority action when addressing barriers to achieving UHC in the WHO European Region.

Methodology

A methodological approach was developed with input from several WHO programme areas, including work on the publication *Health systems respond to noncommunicable diseases: time for ambition*,⁵ and refined during the assessment process. The assessments were a joint effort between WHO and the countries assessed, with the full involvement of WHO country offices. The steps in the assessment included:

- a preliminary document review, including health policy and strategy documents, sexual and reproductive health and child and adolescent health strategy documents, UHC guiding documents, service package descriptions and similar;
- a country visit, including:
 - interviews with policy-makers from the ministry of health, health facility managers (primary care and hospital), service providers (doctors, nurses and others) and beneficiaries (patients and clients);
 - visits to health care facilities at primary, secondary and tertiary levels;
- a presentation and discussion of findings and recommendations with key stakeholders at the end of the visit.

Semi-structured questionnaires were developed to conduct interviews with key informants such as, including:

- representatives of the Ministry of Health;
- health facility managers (hospital and primary health care (PHC));
- health workers including nurses, doctors and midwives, where applicable;
- patients and clients, including adolescents;
- partners and stakeholders, including representatives of the United Nations Children's Fund (UNICEF).

Tracer interventions

To assess the extent to which services were available to the people for whom they were intended and at what cost, six tracer interventions were used to analyse health systems performance in depth. These were:

⁵ Health systems respond to noncommunicable diseases: time for ambition. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/health-topics/Health-systems/health-systems-response-to-ncds/publications/2018/health-systems-respond-to-noncommunicable-diseases-time-for-ambition-2018>, accessed 13 February 2020).

- antenatal care, with a focus on pre-eclampsia;
- STIs (excluding HIV);
- transport of sick neonates;
- case management of common childhood conditions, with a focus on pneumonia;
- adolescent-friendly health services, with a focus on sexual and reproductive health;
- immunization.

The tracer interventions were selected to cover the continuum of care, as well as cross-cutting health system issues. They also aimed to capture various aspects of health system capacity in the area of SRMNCAH. For example, antenatal care is a key intervention at the PHC level, providing a platform for important health care functions – including health promotion, screening and diagnosis and disease prevention. The focus was on pre-eclampsia, which is important as hypertension is estimated to cause about 15% of all maternal mortality in Caucasus and central Asian countries.⁶ STIs are among the most common communicable diseases, but people with STIs often face stigma, stereotyping and shame. Transport of sick neonates to referral levels is critical and may be a good indicator for the preparedness and responsiveness of the health system. Management of common childhood conditions focused on pneumonia, which is one of the main contributors to child mortality and a major cause of polypharmacy and overhospitalization. Sexual and reproductive health services are a key intervention for adolescents, but a number of political and cultural sensitivities are still attached to these services. Immunization is a key intervention at the PHC level, including outreach: for the hardest-to-reach families it can also be a bridge to other life-saving care for mothers and children.

The tracer interventions were assessed according to four attributes, using the following key questions.

- Protocols and legislation: do protocols and legislation exist for the intervention package and are they in line with WHO recommendations?
- Scope of services: are the services provided within the intervention package adequate and in line with WHO recommendations?
- Population coverage and/or access: what is the population coverage of the intervention package or the proportion of the target population that has access to the intervention package?
- Quality of services: is the quality of provision of the intervention package adequate?

The attributes were defined to assess different aspects, but they have some overlaps and linkages. For example, if protocols are not updated according to international and WHO standards, the scope of services will be affected. Likewise, if the scope of services does not include all recommended elements of an intervention package, the quality of the service is affected.

In each country report, assessment of each attribute is explained with a short narrative and given a colour code based on a traffic-light system:

- red – considerable need for improvement or equating to service not being provided or totally inadequate care;
- yellow – some need for improvement to reach standards;
- green – good practice or showing little need for improvement.

⁶ Say L, Chou D, Gemmill A, Tunçalp Ö, Moller AB, Daniels J et al. Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health*. 2014;2(6):e323–33. doi:10.1016/S2214-109X(14)70227-X.

Health system barriers

WHO's six building blocks of UHC were used as an analytical framework for the findings and for identification of barriers/challenges in access to and utilization SRMNCAH services (Fig. 1). Each of the areas were examined, but service delivery and safety was mainly described through the tracer interventions.

Fig. 1. The building blocks of UHC



Source: Universal health coverage [website]. Geneva: World Health Organization; 2019 (http://www.who.int/universal_health_coverage/en/, accessed 23 April 2019).

Limitations

The methodology aimed to triangulate information through document reviews, visits to health facilities and interviews with policy-makers, health managers, providers and clients. The depth of the assessments depended on the completeness of documents provided by the national ministry of health and partners, as well as the extent to which the health facilities visited and key informants interviewed were representative and reflect the national context and situation. The appraisals of tracer interventions and health system barriers and challenges represent the judgement of the assessment teams, based on the information obtained. The composition of the assessment teams was different in each country, which may lead to variations in emphasis within findings and conclusions.

Summary of findings

Full coverage of high-quality SRMNCAH services requires well functioning health systems. This include a wide range of issues related to financing, models of service provision, availability of qualified human resources, accessibility to medicines and infrastructure at facilities. This section reviews the health system challenges that may undermine delivery of the SRMNCAH services and prevent progress towards UHC. The findings include information obtained by the document review, searches in existing databases and findings from country visits, including those related to the tracer interventions.

Health system governance for SRMNCAH

A national health policy is an important step towards a rights-based approach to health, to understand the priorities set by government and the political commitment to them. The extent to which these commitments were met is reviewed in the section on health system financing. To ensure that national health policies make progress towards UHC, it is important that they adequately address the needs of women and men, as well as aiming to leave no one behind.

The existence of programmes and strategies that detail specific actions required for this area towards UHC and in line with national strategies is of high importance for SRMNCAH. The main findings of the assessments include the following.

- All the assessed countries except Azerbaijan have a medium/long-term national health policy or strategy outlining objectives and principles for health and health care services for the population. The strategies have different start- and end-points, and the formulation of objectives varies. Achieving UHC is a directly stated goal only in the strategies of Albania and Kyrgyzstan, but elements of UHC such as equity in access and adequate quality of services are included in all of them.
- Financial risk protection is directly mentioned in Kazakhstan’s strategy as “ensuring a guaranteed volume of free health care services” and in the Republic of Moldova’s strategy as “ensuring economic and social security of the population”.
- Despite ambitious goals and targets of strategic documents, funding and implementation in the area of SRMNCAH do not always back up these intentions.
- All the countries have maternal and child health programmes in place. In Romania, for example, the health strategy also gives special attention to women’s and children’s health and nutrition status. The priority of maternal and child health is also reflected in most health insurance schemes (see the section on health system financing for SRMNCAH), through which services should often be provided free of charge, according to the relevant policies.
- Beyond maternal health, other areas of sexual and reproductive health are less prominently covered. Only Albania and the Republic of Moldova have a sexual and reproductive health strategy in place, despite the Action Plan for Sexual and Reproductive Health and its resolution, which were adopted by the 66th session of the WHO Regional Committee for Europe in September 2016, encouraging national adaptation.⁷

Table 1 sets out a summary of the national assessments’ findings on health system governance.

⁷ Action Plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind. Copenhagen: WHO Regional Office for Europe; 2016 (<http://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health/publications/2016/action-plan-for-sexual-and-reproductive-health-towards-achieving-the-2030-agenda-for-sustainable-development-in-europe-leaving-no-one-behind-2016>, accessed 18 November 2019).

Table 1. Summary of findings on health system governance

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
A declared policy for UHC, including: equity in access health services of high enough quality protection against financial risk	National Health Strategy, ^a including: investing in population health through a life-course approach provision of UHC for all strengthened citizen-oriented health systems improved governance and cross-sectoral cooperation for health	No national health strategy available when the assessment took place	“Densauilyk” State Health Programme for 2016–2019 and Code of Health, ^b including: ensuring equity of citizens in access to safe, effective and quality health care solidarity of state, citizens, employers and employees in strengthening individual and public health ensuring access to health care ensuring guaranteed volume of free health care services	“Healthy person – prosperous country” Health Strategy for 2019–2030, ^c including: protecting health ensuring access to essential high-quality services strengthening PHC decreasing financial hardship for all people and communities, in pursuit of UHC by 2030	National Public Health Strategy for 2014–2020, ^d including: improving population health and reducing inequities in health by enhancing the state public health surveillance service to carry out essential public health operations and provide accessible and high-quality public health services at the individual, community and population levels	National Health Strategy 2014–2020, ^e including: equal access to essential services cost-efficiency and evidence-based approaches optimization of health services with a focus on preventive services and interventions decentralization partnership with all actors that can help improve health status
Maternal, child and adolescent health policy/programme	Maternal and child health programmes in place	Maternal and child health programmes in place	Maternal and child health programmes in place	Maternal and child health programmes in place	Maternal and child health programmes in place	Health strategy gives special attention to women’s and children’s health and nutrition status
Sexual and reproductive health strategy	Sexual and reproductive health strategy in place for 2017–2021	No sexual and reproductive health policy/strategy in place	No sexual and reproductive health policy/strategy in place	Sexual and reproductive programme in place, not a strategy	Sexual and reproductive health strategy in place	No sexual and reproductive health policy/strategy in place

Table 1. (contd)

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Child and adolescent health strategy	In process of development	In place ^f	In place ^f	In place ^f	In process of development	No strategy ^f

^a Viewing the Albanian National Health Strategy through the lens of WHO instruments and tools for health policy-making. In: WHO/Europe [website]. Copenhagen: WHO Regional Office for Europe; 2017 (<http://www.euro.who.int/en/countries/albania/news/2017/03/viewing-the-albanian-national-health-strategy-through-the-lens-of-who-instruments-and-tools-for-health-policy-making>, accessed 22 November 2019);

^b T. Sultangaziev: main objective of “Densaulyk” program is to improve health of Kazakhstan population (video). In: Strategy 2010 [website]. Nur-Sultan City: Strategy2050.kz Information Agency; 2019 (<https://strategy2050.kz/en/news/37610/>, accessed 22 November 2019).

^c Kyrgyzstan adopts new health strategy for 2019–2030. In: WHO/Europe [website]. Copenhagen: WHO Regional Office for Europe; 2019 (<http://www.euro.who.int/en/countries/kyrgyzstan/news/2019/01/kyrgyzstan-adopts-new-health-strategy-for-20192030>, accessed 22 November 2019);

^d National Public Health Strategy for 2014–2020. Chisinau: Ministry of Health; 2013 (<https://ansp.md/index.php/programme-si-strategii/>, accessed 22 November 2019);

^e Strategia Nationala de Sanatate 2014–2020. Sanatate pentru prosperitate [National Health Strategy 2014–2020. Health for wealth]. Bucharest: Ministry of Health of Romania; 2014 (<http://www.ms.ro/wp-content/uploads/2016/10/Anexa-1-Strategia-Nationala-de-Sanatate-2014-2020.pdf>, accessed 21 November 2019);

^f Situation of child and adolescent health in Europe. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/publications/abstracts/situation-of-child-and-adolescent-health-in-europe-2018>, accessed 22 November 2019).

The document review conducted also highlighted two key issues related to multisectoral policies that require attention: violence against women and children and sexuality education.

Multisectoral policies – example of violence against women and children

Violence against women and children is a major global public health problem and a violation of women's and children's human rights. It leads to negative physical, sexual and reproductive and mental health outcomes. WHO estimates that one in four women in the European Region will experience violence on the basis of gender at one point in their lives, at least. A WHO report also found that one in ten children in the Region had been sexually abused, and one in four had experienced physical abuse.⁸

Taking into account the complexity of underlying causes and risk factors of violence against women, it is now widely recognized that the response to violence against women should be multisectoral, with the health sector playing an important role. Health care providers are often the first professionals who may detect child abuse and with whom survivors of intimate-partner violence and sexual violence come into contact; they are also identified by abused women as those they would trust most to disclose abuse to. At the same time, violence against women and discrimination by gender can limit access to health services, especially sexual and reproductive health services.

SRMNCAH services such as antenatal and child care provide specific opportunities to enquire about violence against children and intimate-partner violence among women for whom barriers to accessing health care may exist. They also allow for the possibility of follow-up during antenatal care with appropriate supportive interventions, such as counselling and empowerment interventions. Furthermore, WHO has developed specific evidence-based clinical and policy guidelines and manuals to raise health care providers' awareness of violence against women and to support them in their responses.

Main findings of the document review include the following.

- Data are limited and underreported in all countries. In Kazakhstan, for example, health workers mentioned that the reasons for underreporting include the fact that cases are coded as "external causes". Furthermore, many women did not want to report and pursue the cases legally, and prosecution of acts of violence can be undertaken only when a victim lodges a complaint.
- Services for victims of gender-based violence are limited in all countries. In Kazakhstan, some patronage nurses have been specifically trained to deal with these cases, and in the Republic of Moldova women victims of violence are in general offered emergency services free of charge. In general, however, support and shelters are provided mostly through nongovernmental organizations (NGOs); this may not be sustainable and sufficient.
- It is encouraging that two countries (Albania and the Republic of Moldova) have developed national strategies to prevent and combat violence against women, along with action plans. Further, a pilot action plan has been established under the Kazakhstan Free from Domestic Violence Project in southern Kazakhstan.

Table 2 sets out a summary of recent conclusions from United Nations human rights treaty bodies relevant to violence against women in the context of SRMNCAH.

⁸ European status report on preventing child maltreatment. Copenhagen: WHO Regional Office for Europe; 2018 (<http://www.euro.who.int/en/publications/abstracts/european-status-report-on-preventing-child-maltreatment-2018>, accessed 18 November 2019).

Table 2. Summary of recent conclusions on violence against women

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Data availability	Cases of gender-based violence against women remain underreported, owing to women's limited access to legal aid services, especially in rural and remote areas, as well as the absence of hotline services for women who are victims of such violence.	Cases of sexual harassment and violence – particularly domestic violence – remain high, and are often tolerated and are underreported because of a culture of silence. Systematic collection of data on domestic violence is lacking.	Violence against women – including domestic violence, sexual violence and rape – is largely underreported owing to a culture of silence perpetuated by persistent societal stereotypes. Cases of domestic violence are underreported owing to a culture of silence, resulting in impunity.	Domestic violence against women and children is prevalent and underreported. There is a lack of statistical information disaggregated by age, nationality and relationship between the victim and the perpetrator on violence against women and its causes.	The rate of reporting of cases of sexual violence, including rape, is low.	The capacity of the public system to identify, report and address cases of violence, abuse and neglect of children, as well as sexual exploitation and abuse, in a cross-sectoral manner is limited.

Table 2. (contd)

	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Intersectoral policies and laws	<p>Reducing gender-based violence and domestic violence is one of the strategic goals highlighted in the National Strategy on Gender Equality and its Action Plan for 2016–2020.^a</p> <p>A lack of coordination among responsible entities, and the lack of necessary skills and capacity among responsible staff, results in the insufficient implementation of the national referral mechanism (aimed at preventing and providing protection from gender-based violence).</p>	<p>Concerns surrounding the current laws and practices regarding violence against women include: limited enforcement of existing legislation; courts reportedly using reconciliatory measures for first-time offenders without considering the victim’s opinion or safety; lack of implementation of the Law on the Prevention of Domestic Violence, as reflected by the modest number of cases reported and long-term and short-term protection orders issued.</p> <p>the fact that the prosecution of acts of violence can be undertaken only when a victim lodges a complaint.</p>	<p>A pilot action plan has been established under the Kazakhstan Free from Domestic Violence Project in southern Kazakhstan.^a</p> <p>Concerns related to impunity of perpetrators include: a distinction in the Criminal Code regarding acts of violence against women that are amenable to settlement when the alleged perpetrator reconciles with the victim and undertakes to “make good for the harm” and other offences that are subject to prosecution; the fact that the prosecution of acts of violence can be undertaken only when a victim lodges a complaint.</p>	<p>Domestic violence that causes slight physical harm to health or physical or psychological suffering is addressed under the administrative liability code, rather than being subject to criminal sanctions.</p> <p>Inaction on the part of law enforcement officials and the courts is common in cases of domestic violence: many cases are considered a private matter and referred to community elders courts.</p>	<p>A 2018–2023 National Strategy to Prevent and Combat Violence against Women and Domestic Violence and a 2018–2020 Action Plan have been approved.^a</p> <p>Violence against women, including domestic violence, is still pervasive in the country, and prosecution of perpetrators and protection of victims remain challenging.</p>	<p>Concerns related to the policing and legislation of violence against women include: police intervening in cases of gender-based violence against women only upon court mandates; use of mediation in cases of domestic violence; insufficient collaboration between courts, police and social workers in cases of domestic violence; limited scope of existing legislation on gender-based violence against women and on protection orders; insufficient capacity-building provided to the judiciary, police and health and social workers on gender-sensitive treatment of victims.</p>

Table 2. (contd)

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Services	Concerns related to services for victims of gender-based violence against women include: an insufficient number of shelters; restrictive criteria for admissions to such shelters; a lack of medical and psychological rehabilitation services for women; a frequent failure to enforce protection orders and emergency protection orders.	Concerns related to services for victims of gender-based violence against women include: the limited number of support and referral centres for victims of domestic violence, which are mainly run by NGOs: currently only three state-funded shelters are in place.	Protective measures and support services for victims of violence, including state funding for crisis centres, remain insufficient.	Victim protection services and enforcement measures are insufficient, given the absence of shelters for victims.	Provision of recovery and reintegration services for victims of trafficking is insufficient.	Concerns related to the provision of support for victims of violence include: the requirement to present identity documents to gain access to shelters and health services; restricted access to legal and psychological counselling; a limited number of shelters and crisis centres for victims.

^a National reviews and progress reports on implementation of the Beijing platform for action, 2019.

Sources: Committee on Economic, Social and Cultural Rights [website]. Geneva: Office of the United Nations High Commissioner for Human Rights; 2019 (<https://www.ohchr.org/en/hrbodies/cescr/pages/cescrindex.aspx>, accessed 18 November 2019); Beijing+25 Regional Review Meeting, 29–30 October 2019. In: UNECE [website]. Geneva: United Nations Economic Commission for Europe; 2019 (<http://www.unece.org/beijing25.html>, accessed 22 November 2019).

Multisectoral policies – example of sexuality education

A significant body of evidence⁹ shows that comprehensive sexuality education enables children and young people to develop accurate and age-appropriate knowledge, attitudes and skills; positive values, including respect for human rights, gender equality and diversity; and attitudes and skills that contribute to safe, healthy, positive relationships. Studies also highlight that comprehensive sexuality education, among others, is associated with higher rates of contraceptive use and lower rates of teenage pregnancies and abortions.¹⁰

Only Albania, which has the lowest adolescent birth rate among the assessed countries, has mandatory sexuality education in schools and provided in youth centres. In the other countries, sexuality education is either not part of the curriculum or is optional and depends on individual teachers.

Table 3 sets out a summary of evidence on sexuality education legislation and policies and their implementation.

Health system financing for SRMNCAH

Financing and coverage of SRMNCAH services is of particular interest for this assessment. Main findings of the country assessments include the following.

- Government expenditure on health as a proportion of gross domestic product (GDP) varies between 1% and 4% in the assessed countries. This is well below the average in the WHO European Region, and general government expenditure on health in the European Union (EU) was 7% of GDP in 2017. In addition, given the relatively low GDP per capita in most of the countries, total government health expenditure is also at the lower end, leading to relatively small public resources spent on health. Government expenditure on health as share of total government expenditure varies from 2.8% to 14.7%, with most of the assessed countries below the EU average of 13.9%.
- It is not possible to track expenditure for specific SRMNCAH services but, overall, high out-of-pocket (OOP) payments are a challenge in all countries. The stated benefit packages display government intentions to move towards UHC, but the assessments show that all the countries face challenges in full implementation of promised benefits. This contributes to moderate to high OOP spending in all the countries, varying from 21% of total health spending in Romania to 79% in Azerbaijan, and accordingly low financial protection against catastrophic health expenditure.
- Most of the assessed countries do not apply official co-payments at PHC level for a comprehensive set of services, but several have co-payments for referral care. Informal payments continue to be a part of hospital and specialist care financing. In Albania, co-payments are incurred for outpatient medicines. People who are not covered by insurance are entitled for free visits at the PHC level, but they have to pay for medicines and pay fees if referred to upper levels of care. People who bypass PHC pay fees for consultations or examinations, despite their insurance status. In Azerbaijan, all services provided at state health facilities are fully state funded, although the exemption of many specialist services creates a space for user charges and charges for pharmaceuticals, which are not covered. Smaller flat co-payments apply for hospital admissions in Romania and Kyrgyzstan; deliveries and treatment of children under 5 years of age are, however, exempted in the latter. No formal co-payments apply in Kazakhstan and the Republic of Moldova.

⁹ International technical guidance on sexuality education. Paris: United Nations Educational, Scientific and Cultural Organization; 2018 (<https://www.who.int/reproductivehealth/publications/technical-guidance-sexuality-education/en/>, accessed 18 November 2019).

¹⁰ Sexuality education in Europe and central Asia. Cologne: Federal Centre for Health Education (BZgA); 2018 (<https://www.bzga-whocc.de/en/publications/report-on-sexuality-education-in-europe-and-central-asia/>, accessed 18 November 2019).

Table 3. Summary of evidence on sexuality education

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Laws and policies on sexuality education	The country passed the Act on Comprehensive Sexuality Education for Young People in Albania (2012). ^a	No national policy or law explicitly supports sexuality education in schools.	No national policy or law explicitly supports sexuality education in schools. ^a	No specific law or policy on comprehensive sexuality education is in place.	A policy on sexuality education exists.	Mandatory age-appropriate education on sexual and reproductive health and rights is absent from the school curriculum, and training of teachers in this field is lacking.
Implementation of sexuality education	A sexuality programme called “life skills and sexuality education” is being implemented. It is mandatory and includes 140 teaching hours for ages 10–18 years. ^a Sexuality education is also provided in youth centres. ^a	“Lifestyle education” pilots that include sexual and reproductive health have been implemented in secondary schools, but are not mandatory.	Sexuality education is currently not part of the school curriculum. ^a	Since 2015, sexuality education has been integrated into the subject “healthy lifestyles” in grades 6–11, for 10 hours a year. It is not mandatory, however, and each teacher decides whether to include it. The subject is delivered differently depending on the teacher’s preparedness, the level of religiosity in the region and so on. ^a	Compulsory sexuality education is lacking in schools, despite legal obligations.	Primary and secondary schools can implement an optional school subject “education for health” for grades 1–12 that includes sexuality education. ^b

^a Sexuality education in Europe and central Asia. Cologne: Federal Centre for Health Education (BZgA); 2018 (<https://www.bzga-whocc.de/en/publications/report-on-sexuality-education-in-europe-and-central-asia/>, accessed 18 November 2019).

^b Beijing+25 Regional Review Meeting, 29–30 October 2019. In: UNECE [website]. Geneva: United Nations Economic Commission for Europe; 2019 (<http://www.unecce.org/beijing25.html>, accessed 22 November 2019).

- Provider payment mechanisms at times provide incentives for underutilization of PHC and overutilization of hospital care for both patients and providers. Capitation payment in primary care is a low-powered incentive compared to the fee-for-service and case-based payments used for specialist and hospital care in many countries. Other examples include drugs being free of charge at hospitals but not at the PHC level, meaning that parents prefer their children to be treated in hospitals. Pull factors beyond financial incentives also lead patients to prefer specialist and hospital services, such as better availability of diagnostics and laboratory tests, and greater capacity of health workers to resolve issues.
- Prioritization of limited government resources for health is essential. Most of the countries have vague criteria and processes for deciding which services and medicines should be included in the health benefit packages and these are often not applied systematically. Health technology assessments and other instruments for applying criteria are rarely used. This led to questions about how and why certain services were included and others were not. For example, in the Republic of Moldova a fixed number of in vitro fertilization cases are covered annually by mandatory health insurance, while emergency contraception and human papillomavirus (HPV) vaccination are not covered. In addition, only the process of transfer of the embryo into the uterus is covered. All other investigations, preparatory stages and any treatment – including relatively expensive drugs – are paid out of pocket by the couple. This raises equity concerns, as the government subsidy may only benefit those who can pay for additional needed services.
- The official state health benefit packages and/or insurance schemes are often all-inclusive, covering a wide range of SRMNCAH and other services. They are, however, often underfunded, leading to rationing and OOP payments at the provider level. The assessments showed that, although health services related to pregnancy and for children are often fully or partly subsidized, informal payments for SRMNCAH services such as antenatal and delivery care and medicines were reported in Albania, Azerbaijan, Kyrgyzstan, the Republic of Moldova and Romania. A recent study in Kyrgyzstan¹¹ showed that pregnancy and related conditions were among the most frequent payment category (76% in 2013), but the amounts paid were among the lowest of all specialties. Stockouts of supposedly free medicines due to problems in forecasting were reported in Azerbaijan, Kazakhstan and the Republic of Moldova, requiring payments from patients.
- Several countries have introduced a small payroll tax to complement general tax funding for health services (including Albania, Kyrgyzstan and the Republic of Moldova), while a few have introduced payroll tax as their main funding source (such as Romania). In both instances, the introduction led to a closer linkage between contribution payments and entitlements for some services in the benefit package. In contexts of high levels of informal and agricultural economies, this policy has translated into potentially vulnerable populations (such as Roma populations, women with weak labour market attachment and similar) facing larger coverage gaps. This means, typically, that non-contributors face greater user charges and lack of coverage for outpatient medicines. These groups can be fairly large proportions of the population – for example, 25% in Kyrgyzstan, 14% in the Republic of Moldova and 13% in Romania.
- Alongside the state-guaranteed benefits programmes and/or health insurance schemes, some SRMNCAH services are covered through “vertical” national health and/or public health programmes. This may be inefficient, and there are risks that those services are not included in the health benefit package when the vertical programmes are ending. Essential SRMNCAH services should therefore be part of the health benefit packages as much as possible.
- The inclusion of SRMNCAH in benefit packages varies from country to country. In Albania, children and students are subsidized for health insurance contributions, as are other groups including unemployed people, disabled people, war veterans, retired people and HIV patients. All citizens are entitled to free emergency care, free preventive check-ups and free visits to a PHC provider, regardless of insurance status. In principle, all services provided at state health facilities in Azerbaijan are fully state funded, but

¹¹ Can reductions in informal payments be sustained? Evidence from Kyrgyzstan, 2001–2013. Copenhagen: WHO Regional Office for Europe; 2016 (<http://www.euro.who.int/en/countries/kyrgyzstan/publications/can-reductions-in-informal-payments-be-sustained-evidence-from-kyrgyzstan,-20012013-2016>, accessed 13 February 2020).

the scope of the basic benefit package is not fully defined and the mandatory health insurance scheme is not yet rolled out. In Kazakhstan, the state-guaranteed benefit package is relatively comprehensive and covers all citizens. Almost all SRMNCAH services are covered, except contraceptives. Kyrgyzstan's national State-guaranteed Benefit Package identifies pregnant women, women during delivery, women with pregnancy and/or delivery complications and children under 5 years as beneficiaries entitled to receive hospital care entirely free of charge, without co-payments, and to pay only 50% of outpatient medicines. Insured citizens have to co-pay 50% for outpatient medicines and a flat rate for hospital services. Uninsured citizens pay 100% for outpatient medicines and higher co-payments for hospitalization. All citizens – regardless of insurance status – are entitled to free emergency care and primary care (including a limited number of medicines). In the Republic of Moldova, services for pregnant women, women in delivery and postpartum, children aged 0–18 years and some other defined vulnerable groups are fully covered by the government. In addition, access to emergency and primary care is universal, regardless of insurance status. The mandatory social health insurance in Romania also exempts certain population groups from paying contributions: pregnant women and children and young people up to 26 years old if they are enrolled in any form of education or are leaving a child protection institution and have no income. In addition, other groups such as people with disabilities, war veterans and their widows are exempted from co-payments.

Table 4 sets out a summary of findings on health system financing.

Table 4. Summary of findings on health system financing

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Government expenditure on health as a proportion of GDP (2016) ^a	3%	1%	2%	3%	4%	4%
Government expenditure on health as a proportion of total government expenditure (2017) ^a	14.7%	2.8%	7.9%	6.2%	11.6%	12.1%
OOP payments as a proportion of current health expenditure (2016) ^a	58%	79%	36%	58%	46%	21%

Table 4. (contd)

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
General description of health benefit package	<p>A health benefit package covered by the Compulsory Health Insurance Fund covers a wide range of SRMNCAH services.</p> <p>However, HPV vaccination, emergency contraception and abortion – except in case of miscarriage or for medical reasons – are not covered.</p>	<p>A state-guaranteed basic benefit package covers a limited range of SRMNCAH services such as antenatal and pregnancy care.</p> <p>However, contraceptives – including emergency contraception, micronutrient supplementation, STI treatment, HPV vaccination, cervical cancer screening and treatment – are not covered.</p>	<p>A state-guaranteed benefit package covers a wide range of SRMNCAH services. However, contraceptives are not fully covered (choice is limited to injectables), and emergency contraception and HPV vaccination are not covered.</p>	<p>The national State-guaranteed Benefit Package, Additional Drug Programme and National Health Insurance Fund cover a wide range of SRMNCAH services.</p> <p>However, contraceptives are not fully covered (choice is limited to injectables and intrauterine devices (IUDs); certain hormone pills are subsidized). HPV vaccination, cervical cancer screening and treatment, emergency contraception and abortion – except on medical grounds – are not covered.</p>	<p>A health benefit package covered by a mandatory health insurance scheme covers a wide range of SRMNCAH services.</p> <p>However, contraceptives are covered only for socially vulnerable women. Emergency contraception, HPV vaccination and abortion – except for women in difficult socioeconomic situations – are not covered.</p>	<p>A health benefit package covered by social health insurance scheme covers a wide range of SRMNCAH services.</p> <p>However, HPV vaccination and contraceptives, including emergency contraception and abortion – except for women in difficult socioeconomic situations – are not covered.</p>

Table 4. (contd)

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Proportion of population covered by health insurance/government support for uninsured people for certain conditions	<p>Exact coverage of the Compulsory Health Insurance Fund is not known, but it is estimated to be relatively low. All citizens are entitled to free emergency care, preventive check-ups, free visits to a PHC provider and medications (or with small co-payments; on a specific approved list) for chronic conditions following the free preventive check-up and PHC visit. Only insured people receive the rest of services free of charge, on the condition that they follow the referral pathways. Uninsured people have to pay service fees.</p>	<p>Access to health care is a constitutional right of every citizen, but it is not entirely clear what services are provided free of charge and to which groups. No health insurance scheme is in place. A mandatory health insurance scheme is planned from 2020</p>	<p>A state-guaranteed benefit package covers all citizens. A compulsory health insurance scheme is planned from 2020.</p>	<p>The National Health Insurance Fund currently covers 74% of the population, giving entitlement to a defined set of medicines at reduced price and reduced co-payments for inpatient care. The State-guaranteed Benefit Package and Additional Drug Programme entitle all citizens to free emergency care, free primary care (including a limited number of medicines), free outpatient care with referral and inpatient care with a referral and co-payment.</p>	<p>The mandatory health insurance scheme covers about 87% of the population. Access to emergency care, primary care and services of key public health relevance, such as HIV/AIDS, tuberculosis and immunization are universal, regardless of insurance status.</p>	<p>The mandatory social health insurance scheme covers 86% of the population. The minimum package for uninsured people is set on the basis of three main criteria: life-threatening emergencies, epidemic-prone/infectious diseases and birth.</p>

Table 4. (contd)

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Population groups exempt from user charges	Subsidies are available for children, unemployed people, disabled people, war veterans, retired people, students, army recruits, cancer patients and HIV patients.	–	–	The State-guaranteed Benefit Package identifies pregnant women, women during delivery, women with pregnancy and/or delivery complications and children under 5 years as beneficiaries entitled to receive hospital care entirely free of charge, without co-payments.	The government fully subsidizes 16 population groups, including: pregnant women, women in delivery and postpartum; children aged 0–18 years; other vulnerable groups.	Population groups exempted from contribution payments, or for whom contributions are paid by other sources, are: children and young people up to 26 years if they are enrolled in any form of education or are leaving a child protection institution and have no income; pregnant women; war veterans and their widows; victims of political repression during 1945–1989; people with disabilities; chronically ill patients covered by national health programmes.

Table 4. (contd)

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Financial incentives for hospital versus PHC services	PHC facilities are funded based on capitation and historical budgets, with adjustment. Hospitals are funded through global budgets, with some adjustments.	PHC facilities receive funding per capita, while budgeting and planning for hospital-level service provision is based on historical budgets.	PHC facilities receive funding per capita, while case-based funding is in place for hospitals in big cities. In rural settings all facilities receive per capita funding, including hospitals.	PHC is funded based on capitation. Hospitals are reportedly funded according to diagnosis-related groups that are mainly focused on quantity and not quality.	PHC facilities receive funding per capita. Budgeting and planning for hospital-level service provision is based on historical budgets.	PHC facilities are paid by mix of age-weighted capitation and fee for services. Hospitals are funded based on a mix of diagnosis-related groups, case payments, day tariffs, lump sums and fee for services.

Table 4. (contd)

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Co-payment policies	Co-payments are incurred for outpatient medicines, especially if the prescribed medicine is not the first alternative in that therapeutic group of the classification. People who bypass the PHC gateway, whatever their insurance status, pay fees for consultations or examinations.	No formal co-payments are incurred.	No formal co-payments are incurred.	People with expected high expenditure on health are either exempt or are entitled to reduced co-payments for inpatient care. Hospital co-payments are set as flat fees payable on admission. The level of co-payment varies by oblast, level of health facility, patient beneficiary status and exemption category, intervention type and whether the patient has a written referral from a PHC physician. There is an extensive system of exemptions in the State-guaranteed Benefit Package for hospital co-payments, which aims to protect people with high expected health care costs.	No formal co-payments are incurred.	Hospitals charge a small flat co-payment for admission.

^a WHO Global Health Expenditure Database. Geneva: World Health Organization; 2018 (<http://apps.who.int/nha/database/ViewData/Indicators/en>, accessed 19 November 2019).

Essential medicines and health products for SRMNCAH

Essential medicines should be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and at a price the individual and the community can afford. Main findings of the country assessments include the following.

- Medicines are an important component of total health expenditure (the European average was 18% in 2011) and are a main driver of OOP payments in many countries. For example, in Azerbaijan, Kazakhstan and Kyrgyzstan they make up approximately 60% of total OOP expenditure.
- High prices of pharmacological products due to unregulated markets and polypharmacy contribute to high expenditure on medicines. Examples of this from the assessment related to management of common childhood conditions include intramuscular injections of third-generation cephalosporins for non-severe pneumonia, intramuscular injections of vitamin C and provision of homeopathic immune boosters.
- All the countries have a list of subsidized or free medicines, with different levels of co-payment. Medicines for pregnant women, women in delivery and postpartum and children aged 0–18 years are in general on the lists of subsidized or free medicines, with exception of contraceptives, emergency contraception and HPV vaccination. Key informant interviews, however, revealed that even in countries where the drugs on their essential list were supposed to be free (Azerbaijan and Kazakhstan), stockouts in health facilities at times forced patients to purchase their medicines.
- The lists of essential medicines are often of generic drugs. In the Republic of Moldova, there was concern regarding the quality of generic medications usually procured by the state, including hormone pills. While first-generation contraceptives are procured for distribution to young girls in youth-friendly health centres, many clients ask for prescriptions for “better pills”, which they can access in pharmacies.

Table 5 sets out a summary of findings on essential medicines and health products.

Health workforce for SRMNCAH

The health workforce is central to managing and delivering health services, and the ability of health systems to perform well in SRMNCAH and other areas is strongly influenced by the availability of workers with relevant skills, in sufficient numbers and located where they are needed. Main findings of the country assessments include the following.

- All the countries have a system of family doctors at the PHC level, which should act as a one-stop shop and provide a gatekeeping function to higher levels of care. There are, however, major challenges for family doctors to fulfil that role in the area of SRMNCAH.
 - Paediatricians and obstetricians often work at the PHC level along with family doctors, but the roles are not clearly defined and the services are not fully integrated.
 - Family doctors are not always skilled and/or provided with capacity in delivering essential SRMNCAH services, such as IUD insertion and simple STI diagnosis and treatment, causing multiple referrals and fragmentation.
 - Patient interviews indicated that due to referrals to specialists for minor issues and perceived lack of competencies of family physicians, it was sometimes easier to go directly to hospitals, where they could get a full investigation and treatment in one place.
 - The PHC level is often funded on a per capita basis, with few incentives to expand services.

Table 5. Summary of findings on essential medicines and health products

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Essential SRM/CAH medicines and vaccines not included in the health benefit package	HPV vaccination, emergency contraception	Contraceptives, emergency contraception, micronutrient supplementation, STI treatment, HPV vaccination	HPV vaccination, contraceptives – including emergency contraception	HPV vaccination, emergency contraception	Emergency contraception, HPV vaccination	HPV vaccination, contraceptives – including emergency contraception
Percentage co-payment for drugs	For the drugs on the positive list, co-payments vary from 0% for medicines to treat cancer and multiple sclerosis; to 25–35% for gynaecological medicines, other medicines treating ulcers and urinary infections; and to 50% for antibiotics and dermatological medicines. Children aged under 12 months are also exempt from co-payments.	No co-payment applies for medicines on the positive list. For all other medicines citizens have to pay fully out of pocket.	No co-payment applies for medicines on the positive list. For all other medicines citizens have to pay fully out of pocket.	Under the Additional Drug Programme for insured citizens, the population is supposed to be able to access selected medicines from contracted pharmacies, with a reimbursement rate set at 50% of the median wholesale price.	For drugs on the positive list co-payments are 0%, 30%, 50% or 70% of the cost of treatment for various chronic conditions (including cardiovascular diseases, diabetes and asthma), for ambulatory treatment of acute conditions and for day hospital cases. Children under 18 years are fully compensated.	For pharmaceuticals provided during ambulatory care, patients pay 10% of the reference price for generic prescription drugs and 50% for branded or innovative prescription drugs. For expensive prescription drugs with prices higher than the reference price, the patient's contribution can be as high as 80%. Children up to 18 years, students without income aged 18–26 years and pregnant and postpartum women are fully compensated.

- The roles of nurses and midwives are not clearly defined in the PHC context and their work may be underutilized to expand, enhance and coordinate the reach of PHC services.
- Recruitment and retention of health workers, particularly in rural areas, is seen as a challenge in all the countries. The main reasons reported are low salaries and poor working conditions, despite incentive schemes (extra salary, additional training) in some countries to attract health workers to rural areas. Migration of staff to other countries was also cited as a problem in four of the six countries assessed.
- Systems of continuing medical education exist in all the assessed countries, but it is not clear to what extent this is tailored to the PHC context and health professionals' needs, and to what extent it is expected of all relevant health professionals, including nurses and midwives.
- Health work in many countries, including those assessed, is among the worst paid professions. This may have implications for the coverage of rural and isolated areas, where low salaries, poor infrastructure, absence of proper lodging and poor education possibilities were mentioned as the main reasons for not wishing to work in rural areas.
- Although a general shortage of staff was mentioned as a major problem in several of the countries, health workforce data show a more varied picture. Physician density per 1000 population shows that Albania, Kyrgyzstan and Romania are at the lower end, whereas the other countries have comparable density to that in countries such as Denmark, Hungary and Spain. All the assessed countries have fewer general practitioners per 100 000 population than the average for the WHO European Region; Azerbaijan, Kazakhstan and Kyrgyzstan have 50% or less than this figure. At the same time, Azerbaijan and Kazakhstan have higher numbers of paediatricians and obstetricians per 100 000 population than the European average, whereas Albania, Kyrgyzstan and Romania (with regard to paediatricians only) have considerably lower numbers. The density of nursing and midwifery personnel per 100 000 population for all countries is comparable to the situation in Hungary and Spain.
- Rather than involving a general shortage of staff, problems may often be a question of the roles and proportion of specialists (paediatricians and obstetricians) versus general practitioners, depending on the envisaged model of PHC and – very importantly – the distribution of staff at the PHC versus hospital level and in rural versus urban locations.
- Updated human resources strategies and plans, with forecasting of staffing needs and education curricula, were not fully ascertained in the assessment.

Table 6 sets out a summary of findings on health workforce.

Table 6. Summary of findings on health workforce

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Physician density per 1000 population (year) ^a	1.2 (2009)	3.4 (2014)	3.3 (2014)	1.9 (2014)	3.2 (2015)	2.3 (2009)
General practitioners per 100 000 population (year) ^b	56 (2013)	23 (2014)	36 (2014)	30 (2013)	49 (2014)	57 (2013)
Nursing and mid-wifery personnel density per 1000 population (year) ^a	3.9 (2009)	6.9 (2014)	8.3 (2009)	–	4.5 (2015)	5.9 (2009)
Paediatricians per 100 000 population (year) ^b	5.1 (2013)	41.8 (2014)	36.1 (2014)	9.3 (2014)	13.6 (2014)	11 (2013)
Obstetricians per 100 000 population (year) ^b	6.3 (2013)	19.9 (2014)	28.4 (2014)	17.1 (2014)	17.8 (2014)	10.7 (2013)

Table 6. (contd)

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Recruitment and retention of PHC level staff	Fewer young people are entering the medical profession. Trained doctors are migrating owing to better working conditions elsewhere.	Difficulties are experienced in recruitment and retention of health workers, particularly in rural areas – a main reason being low salaries.	Difficulties are experienced in attracting health workers in the obstetric field owing to a punitive system. Salaries are not seen as competitive for health workers in general.	Difficulties are experienced in recruitment and retention of health workers, particularly in rural areas – main reasons being low salaries and poor working conditions. Migration of specialists to foreign countries, especially the younger generation, is causing an increasingly ageing health workforce.	Difficulties are experienced in recruitment and retention of health workers, particularly in rural areas – main reasons being low salaries and poor working conditions. Migration of specialists to foreign countries, especially the younger generation, is causing an increasingly ageing health workforce.	Fewer young people are entering medical schools, and the medical profession is becoming less attractive and prestigious. Doctors and nurses are migrating to other EU countries.
Distribution of staff: rural versus urban	Shortages of medical specialists, particularly paediatricians and neonatologists, are experienced in suburban and rural areas.	Staffing is unbalanced between urban and rural areas.	Specialists are lacking in rural areas.	Staffing is unbalanced between urban and rural areas.	Staffing is unbalanced between urban and rural areas.	Hospitals, especially in rural areas, cannot fill vacancies for specialists.
Incentives to attract staff to rural areas	Yes	No	Yes	Yes	Yes	No

Table 6. (contd)

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Continuous medical education	A system for continuing education for health care personnel in various programmes and training, with a system of accreditation, is in place.	240 credit hours of continuing medical education are needed to take an examination every five years in order to practise.	A system for continuing education for health care personnel exists and is partly supported at the rayon level with offers of continuous medical education as an incentive to work in rural areas.	No information	A system for continuing education for health care personnel exists.	A system for continuing education for health care personnel in various programmes and training, with a system of accreditation, is in place.

^a WHO Global Health Observatory (GHO) data [database]. Geneva: World Health Organization; 2019 (<https://www.who.int/gho/en/>, accessed 19 November 2019).

^b European Health Information Gateway [database]. Copenhagen: WHO Regional Office for Europe; 2019 (<https://gateway.euro.who.int/en/>, accessed 19 November 2019).

Health statistics and information systems for SRMNCAH

A well functioning health information system is a prerequisite for informed decision-making at all levels. Health information systems have improved over recent years, and systems are in the process of being digitalized in all the countries. Main findings include the following.

- Maternal mortality information is still a sensitive issue. Some of the national assessments found that clinics reportedly tried to avoid reporting maternal deaths for reasons of prestige and from fear of punitive measures.
- Data are mainly reported upwards in the system and used for budgeting and payment purposes, rather than in policy-making processes at different levels. Capacity for analysis and checking the reliability and feasibility of data at lower levels of the health system is reportedly limited.
- The use of data for policy-making processes is also hampered by multiple databases, not used in conjunction, and each requiring separate data collection. For example, Albania has three parallel STI reporting systems without sufficient linkages.
- Multiple Indicator Cluster Surveys and Demographic and Health Surveys have been conducted in all the countries except Romania. However, these have only been done in Albania and Kyrgyzstan in recent years, and there are no reports of use of additional national surveys to facilitate better understanding of the data.
- Data on family planning use (contraceptive prevalence rate and unmet needs for family planning) are lacking as a result of deficiencies in routine health information systems and the lack of survey-based data.
- A major issue for SRMNCAH is the lack of reported disaggregated data. In some instances, the information may exist but it is not being reported and analysed in a disaggregated way. In the case of morbidity, often no disaggregation takes place for age (only below and above 18 years), sex, rural/urban populations, wealth or ethnicity. Without such disaggregation of data, it is difficult to monitor trends along the continuum of care and to target interventions and policies to those most in need, with the aim of achieving UHC.

Table 7 sets out a summary of findings on health statistics and information systems.

Table 7. Summary of findings on health statistics and information systems

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Disaggregation of data	Disaggregation by age, sex, rural/urban location, wealth and ethnicity is limited.	Disaggregation by age, sex, rural/urban location, wealth and ethnicity is limited.	Disaggregated data on morbidity are lacking, with no age disaggregation except below and above 18 years and 0–1, 1–5 years; no disaggregation is available by sex, rural/urban location, wealth or ethnicity.	Disaggregation by age, sex rural/urban, wealth and ethnicity is limited.	Disaggregated data on morbidity are lacking, with no age disaggregation except below and above 18 years; no disaggregation is available by sex, rural/urban location, wealth or ethnicity.	Disaggregation by age, sex, rural/urban location, wealth and ethnicity is limited.
Use of data for policy-making	A paper-based system is still in use, which complicates accurate aggregation of data and data analysis. Motivation for data reporting at lower-level facilities is limited; documentation of information on different reporting forms is time-consuming.	Qualified human resources (data analysts) to check the reliability and feasibility of data are lacking.	Data on health status, quality and the performance of health service providers are not sufficiently used for informed policy-making. No formal mechanisms are in place and capacity for data analysis at lower levels is limited.	Qualified human resources (data analysts) to check the reliability and feasibility of data are lacking.	Each rayon facility reports to the national level; no formal mechanisms are in place and capacity for analysis is limited at rayon level. Data on health status, quality and the performance of health service providers are not sufficiently used for informed policy-making.	Analysis and use of collected data in planning and decision-making are limited.

Table 7. (contd)

Key features	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Use of databases	There is a high level of fragmentation – for example, three parallel surveillance systems for STIs without sufficient linkages are in use.	An integrated health information system that would feed into policy- and decision-making processes at the strategic and operational levels is lacking.	Multiple data registries, which are not used in conjunction, mean that data on health status, quality and the performance of health service providers are not used for informed policy-making.	An integrated health information system that would feed into policy- and decision-making processes at the strategic and operational levels is lacking.	Different institutions collect data that are not used in conjunction, meaning that data on health status, quality and the performance of health service providers are not used for informed policy-making.	There is a high degree of data fragmentation and duplication of data collection. Since the information systems use different software, formats, definitions and standards, communication between and within systems is minimal and data collected are not comparable.
Latest Multiple Indicator Cluster Survey	2003	2000	2015	2018	2012	No information
Latest Demographic and Health Survey	2017–2018	2006	1999	2012	2005	No information

Tracer interventions

As outlined in the methodology section, each of the six tracer interventions was assessed according to four attributes. In the country assessment reports, the findings were introduced with a short narrative and given a colour code, based on a traffic-light system. The tables with colour coding are presented here for all the countries assessed.

Antenatal care

The assessments reviewed antenatal care services and focused on pre-eclampsia. Management of pre-eclampsia is important, as hypertension is estimated to cause about 15% of all maternal mortality in Caucasus and central Asian countries. The main findings across the countries were as follows.

- The WHO recommendations on antenatal care,¹² which include eight contacts during the pregnancy, have been adopted as policies in all but two countries (Azerbaijan and Romania).
- Population coverage is, in general, high for most countries (76–95%). The latest data from Azerbaijan, however, showed coverage of 66% (2011).
- Despite good coverage and updated protocols in most countries, informal payments for services such as ultrasound investigation and certain medicines were reported by key informants in several countries (Azerbaijan, Kyrgyzstan, Republic of Moldova and Romania).
- All countries face challenges with the quality of services in antenatal care. Services are often fragmented: pregnant women have to see many different providers, with multiple referrals. Where family doctors are the main providers of antenatal care, they are often not confident in the detection and management of complications such as pre-eclampsia.
- PHC facilities visited in Azerbaijan, Kazakhstan, Kyrgyzstan and the Republic of Moldova all reported that no or very few cases of pre-eclampsia were seen. Given that it is estimated that pre-eclampsia is present in 2–8% pregnancies overall,¹³ this indicates that the condition is underdiagnosed or not recognized by providers. At the same time, interviews with obstetricians and gynaecologists at the hospital level revealed that they were seeing a high number of severe eclampsia cases. This could indicate that pregnant women present late to hospitals with advanced symptoms, bypassing the PHC level that had not detected their pre-eclampsia.

Table 8 sets out a summary of findings on antenatal care.

Table 8. Summary of findings on antenatal care

Attributes	Rating of countries assessed					
	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Protocols and legislation	Good practice/little need for improvement	Some need for improvement	Good practice/little need for improvement	Good practice/little need for improvement	Good practice/little need for improvement	Some need for improvement

¹² WHO recommendations on antenatal care for a positive pregnancy experience. Geneva: World Health Organization; 2016 (<https://apps.who.int/iris/handle/10665/250796>, accessed 19 November 2019).

¹³ WHO recommendations for prevention and treatment of pre-eclampsia and eclampsia. Geneva: World Health Organization; 2011 (<https://apps.who.int/iris/handle/10665/44703>, accessed 19 November 2019).

Attributes	Rating of countries assessed					
	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Scope of services	Good practice/little need for improvement	Some need for improvement	Good practice/little need for improvement	Good practice/little need for improvement	Some need for improvement	Some need for improvement
Population coverage and/or access	Some need for improvement	Some need for improvement	Good practice/little need for improvement	Some need for improvement	Good practice/little need for improvement	Some need for improvement
Quality of services	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement

STIs

The assessments reviewed STI services, excluding HIV. STIs are among the most common communicable diseases, but people with STIs often face stigma, stereotyping and shame. The main findings of the assessments included the following.

- Management of STIs is often fragmented, with multiple referrals and services that are not fully integrated at the PHC level. In Albania, most clients with suspected STI cases go directly to the tertiary level for consultation and diagnosis, or choose to pay directly for a complete service at private clinics. In Azerbaijan, reactants for laboratory tests provided by the government are reportedly insufficient; when the facilities run out of tests, women are referred to private laboratories. In Kazakhstan, many patients prefer private clinics owing to confidentiality issues and perceived better treatment, despite services being offered free of charge in public facilities. In Romania, patients with STI symptoms, especially from villages, usually bypass the family doctor and present directly to specialists (dermatologists and venereologists), as family doctors do not arrange investigations and provide treatment for STIs. In Kyrgyzstan, laboratory services for STI diagnosis are lacking, forcing patients to access the private sector. In the Republic of Moldova, limited STI treatment is available at the PHC level: family doctors refer patients for treatment to a variety of specialists, such as dermato-venereologists, gynaecologists and infectious disease specialists.
- In all countries testing for STIs is supposedly free, and syphilis testing is done as a part of the antenatal care package. Treatment is, however, often paid for by the patients themselves – either fully or partially – which affects coverage of detection and management of STIs.
- Protocols for management of STIs exist in all countries except Azerbaijan. In Romania, detailed treatment protocols were, however, not available at the time of the assessment.
- Coverage is difficult to estimate, as statistics on the prevalence of STIs – with the exception of syphilis – are inadequate. Part of the reason is that private providers are not required to report cases.
- The absence of accurate statistical data on prevalence of STIs makes it difficult to define the need to include services (diagnostics and treatment) in benefit packages and to fund them from state budget.
- In the majority of cases, treatment is paid out of pocket.

Table 9 sets out a summary of findings on STIs.

Table 9. Summary of findings on STIs

Attributes	Rating of countries assessed					
	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Protocols and legislation	Some need for improvement	Considerable need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement
Scope of services	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement
Population coverage and/or access	Some need for improvement	Some need for improvement	Some need for improvement	Considerable need for improvement	Some need for improvement	Some need for improvement
Quality of services	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement

Transport of sick neonates

Transport of sick neonates to referral levels was chosen as a critical indicator of the preparedness and responsiveness of the health system. The main findings of the assessments included the following.

- In most countries, protocols for the management of preterm and sick neonates are available at the facility level, but protocols and standards for transport of sick neonates – including personnel, medical care during transport, equipment and transport administration – do not exist.
- Transport units are not adequately equipped in many instances, and surfactant, which is critical to treat respiratory distress in premature babies, is only available at the tertiary level. In Albania and Azerbaijan, sick babies are brought in ambulances that are not equipped with specific equipment for safe transportation, and surfactant is only available in referral hospitals in the capital. In Kyrgyzstan, fully equipped neonatal transport ambulances are available in the capital and in some regions, but surfactant is not available in public settings and has to be bought at private facilities. In the Republic of Moldova, only two ambulances are equipped for neonatal transport to cover the whole country. The transport systems are better organized in Kazakhstan and Romania, where specialized transport units (cars and helicopters) are available and surfactant and capacity to manage sick neonates are available at subnational/regional levels.
- Medical staff transporting sick neonates, except in Kazakhstan and Romania, are often not specifically trained.
- There is limited expertise in the management of common conditions for sick neonates – particularly stabilization of the newborn at lower health care levels. Neonates referred to higher levels often arrive with hypothermia and in poor condition.
- In general, remote areas are often more poorly served, with delays in referral.

Table 10 sets out a summary of findings on transport of sick neonates.

Table 10. Summary of findings on transport of sick neonates

Attributes	Rating of countries assessed					
	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Protocols and legislation	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement
Scope of services	Considerable need for improvement	Some need for improvement	Good practice/little need for improvement	Considerable need for improvement	Good practice/little need for improvement	Some need for improvement
Population coverage and/or access	Considerable need for improvement	Considerable need for improvement	Good practice/little need for improvement	Considerable need for improvement	Considerable need for improvement	Some need for improvement
Quality of services	Considerable need for improvement	Considerable need for improvement	Good practice/little need for improvement	Considerable need for improvement	Considerable need for improvement	Some need for improvement

Management of common childhood conditions

The assessments covered management of common childhood conditions, with a focus on pneumonia. The main findings of the assessments included the following.

- Protocols are in line with WHO recommendations in Kazakhstan, Kyrgyzstan and the Republic of Moldova, where Integrated management of childhood illnesses (IMCI)¹⁴ has been implemented at larger scale. National protocols are lacking, not used and/or not in line with international evidence-based standards in the other countries.
- Polypharmacy and overuse of antibiotics are common problems in most countries, which in some instances leads to additional OOP payments for drugs, on top of other harmful effects. A common practice at PHC and hospital levels in Azerbaijan includes non-evidence-based practices such as intramuscular injections of third-generation cephalosporin for non-severe pneumonia, intramuscular injections of vitamin C and provision of homeopathic immune boosters. In Kyrgyzstan, a number of children who looked well were seen at the PHC level for ongoing intramuscular injections, reportedly for respiratory conditions. It was reported that potent antibiotics for pneumonia have to be prescribed frequently at the central level owing to resistance to first- and second-line antibiotics.
- Overhospitalization of cases that could be safely managed as outpatient is also extensive. The total hospitalization rate for pneumonia for children under 5 years is 4–10 times higher in Kazakhstan, Kyrgyzstan, the Republic of Moldova and Romania¹⁵ (no data for Albania and Azerbaijan) than in Spain, Sweden and France. During visits to hospitals, apparently healthy children with a diagnosis of pneumonia occupied beds in paediatric wards.
- In countries with no standard treatment guidelines, such as IMCI, health providers tend to follow their historical knowledge. Where protocols exist, they are frequently not followed.

¹⁴ Integrated Management of Childhood Illness: chart booklet. Geneva: World Health Organization; 2014 (https://www.who.int/maternal_child_adolescent/documents/IMCI_chartbooklet/en/, accessed 19 October 2019).

¹⁵ Hospitalisation rate for pneumonia in children under 5 years. In: European Health Information Gateway [database]. Copenhagen: WHO Regional Office for Europe; 2019 (https://gateway.euro.who.int/en/indicators/cahb_survey_29-hospitalisation-rate-for-pneumonia-in-under-5-children/, accessed 19 November 2019).

- Parents' expectations may put pressure on health providers. In Albania, some parents reportedly expected that even minor illnesses in children should be treated with strong medication and intravenous fluids, and the children should be admitted.
- At times financial incentives for hospital admission are in place for both patients and providers. In the Republic of Moldova, drugs may be free of charge in hospitals but not at the PHC level, meaning that parents prefer their children to be treated as inpatients. Historical budgeting for hospitals rewards a high bed occupancy rate, creating further incentives for hospitals to admit patients.

Table 11 sets out a summary of findings on management of common childhood conditions.

Table 11. Summary of findings on management of common childhood conditions

Attributes	Rating of countries assessed					
	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Protocols and legislation	Considerable need for improvement	Some need for improvement	Good practice/little need for improvement	Good practice/little need for improvement	Good practice/little need for improvement	Considerable need for improvement
Scope of services	Considerable need for improvement	Some need for improvement	Good practice/little need for improvement	Good practice/little need for improvement	Some need for improvement	Some need for improvement
Population coverage and/or access	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement
Quality of services	Some need for improvement	Considerable need for improvement	Some need for improvement	Considerable need for improvement	Considerable need for improvement	Some need for improvement

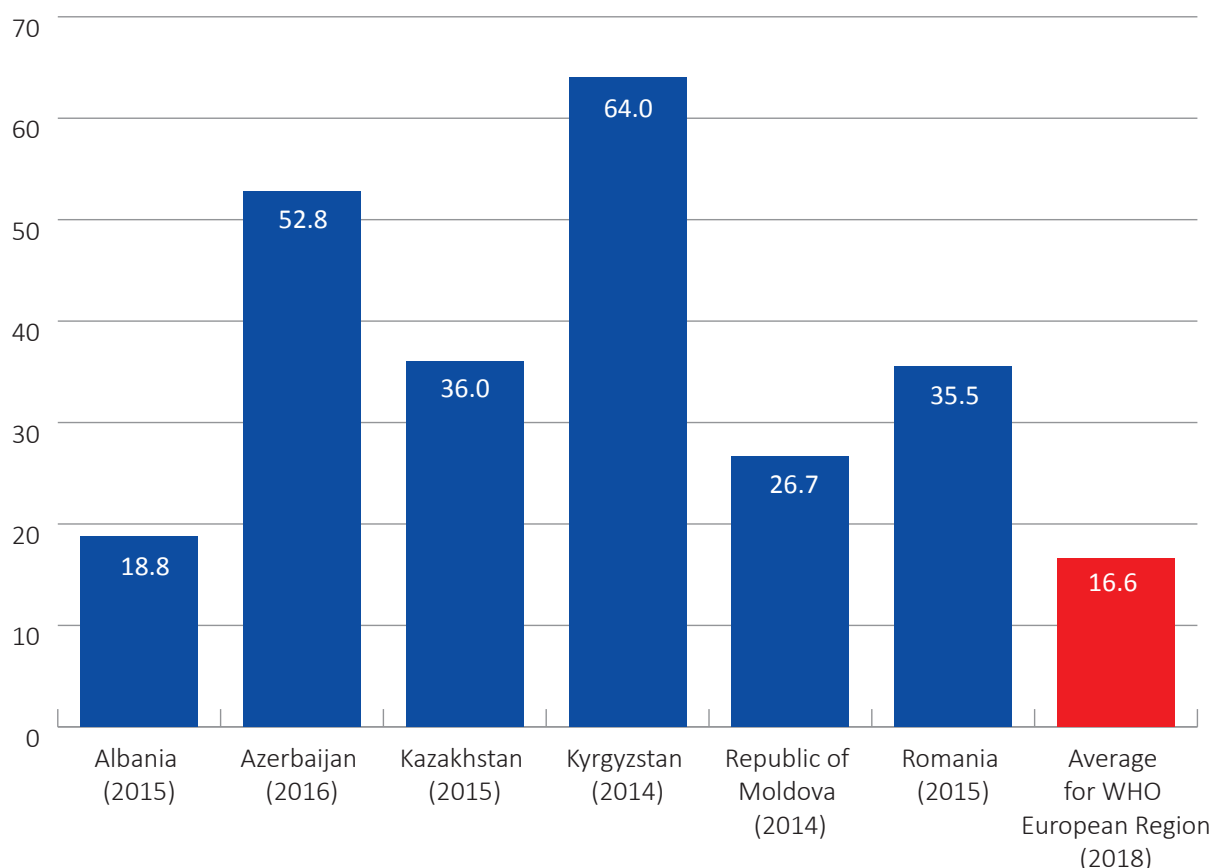
Adolescent-friendly health services

Sexual and reproductive health services for adolescents are a major challenge. All the countries assessed, except Albania, have teenage pregnancy rates well above the average for the WHO European Region (16.6 per 1000 women aged 15–19 years; see Fig. 2).

Furthermore, marriage of girls before the age of 18 years is relatively common in the assessed countries: the proportion of women aged 20–24 years who were married or in a union by the age of 18 years ranges from 7% to 12%.¹⁶ In addition to the health consequences, child marriage often compromises a girl's development through social isolation, interrupting her schooling and limiting her opportunities for career and vocational advancement. Access to services such as sexual and reproductive health and sexuality education in school is therefore further challenged. Early marriage has a number of negative health impacts, including being more likely to be forced into sexual intercourse; being more likely to experience domestic violence; having poor psychological well-being; being vulnerable to poor sexual and reproductive health – such as higher likelihood of early pregnancy and STIs, including HIV; being more likely to face complications from pregnancy; and having less access to health and contraceptive services.

¹⁶ Women married or in a union before age 15 and 18: data by country. In: WHO Global Health Observatory (GHO) data [database]. Geneva: World Health Organization; 2019 (<http://apps.who.int/gho/data/node.main.CHILDMARRIAGE?lang=en>, accessed 22 November 2019).

Fig. 2. Adolescent birth rate per 1000 women aged 15–19 years



Source: Adolescent birth rate: data by country. In: WHO Global Health Observatory (GHO) data [database]. Geneva: World Health Organization; 2019 (<http://apps.who.int/gho/data/view.main.1630AG>, accessed 19 November 2019).

The main findings of the assessments included the following.

- Clear policies and interventions focusing on adolescents are lacking, except in the Republic of Moldova. There, a systematic process has been followed to ensure access of adolescents to sexual and reproductive health services across the country, leading to the establishment of 41 youth-friendly health centres in municipalities and districts.
- Protocols and legislation in Azerbaijan and Kazakhstan preclude adolescents under 18 years accessing services without parental consent. In Kyrgyzstan, legislation on provision of sexual and reproductive health services to adolescents is inconsistent (the reproductive health law states that adolescents can receive health services without awareness of their parents or lawful representatives from 16 years, whereas the Child Protection Law states that no services can be offered to a child under the age of 18 years without parental consent). Where the legislation allows younger adolescents to access services (Republic of Moldova, Romania), health workers are not always aware of such legislation or do not always provide the services.
- Youth-friendly health centres at a larger scale exist only in the Republic of Moldova. In Kazakhstan, a number of regional adolescent-friendly health centres are planned but not yet established. In the other countries, these services are supposed to be provided at the PHC level, but staff often lack qualifications and the facilities do not meet standards for being youth-friendly.
- The scope of services provided is often limited to health information/promotion – adolescents can rarely access contraception, STI treatment or similar services. Lack of confidentiality, particularly when services are provided locally at the PHC level, was mentioned as an important barrier for adolescents seeking care. Mass screenings of children and adolescents are implemented in some countries (Azerbaijan, Kyrgyzstan)

without evidence for benefit, including for tuberculosis with chest photo-fluoroscopy, an outdated and potentially harmful practice.

Table 12 sets out a summary of findings on adolescent-friendly health services, with a focus on sexual and reproductive health.

Table 12. Summary of findings on adolescent-friendly sexual and reproductive health

Attributes	Rating of countries assessed					
	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Protocols and legislation	Some need for improvement	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement	Good practice/little need for improvement	Some need for improvement
Scope of services	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement	Some need for improvement	Considerable need for improvement
Population coverage and/or access	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement	Some need for improvement	Considerable need for improvement
Quality of services	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement	Considerable need for improvement	Some need for improvement	Considerable need for improvement

Immunization

Immunization is a key intervention at the PHC level. For the hardest-to-reach families it can also be a bridge to other life-saving care for mothers and children. The main findings of the assessments included the following.

- In general, the national immunization schedules are consistent with WHO recommendations, with the exception of HPV vaccination, which is not included in any of the countries.
- Immunization coverage is generally high, with three-dose diphtheria, pertussis and tetanus coverage between 82% and 97%. Coverage has, however, shown a decreasing trend in some countries (Republic of Moldova, Romania), and outbreaks of vaccine-preventable diseases have been seen in all the countries in recent years.
- All the countries have subnational/regional differences in coverage, and low coverage is seen in some population groups, including Roma populations. In some countries, contraindications for vaccinations are not always evidence-based, which may delay immunization.

Table 13 sets out a summary of findings on immunization.

Table 13. Summary of findings on immunization

Attributes	Rating of countries assessed					
	Albania	Azerbaijan	Kazakhstan	Kyrgyzstan	Republic of Moldova	Romania
Protocols and legislation	Good practice/ little need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Good practice/ little need for improvement
Scope of services	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement	Some need for improvement
Population coverage and/or access	Good practice/ little need for improvement	Some need for improvement	Good practice/ little need for improvement	Some need for improvement	Some need for improvement	Some need for improvement
Quality of services	Good practice/ little need for improvement	Some need for improvement	Good practice/ little need for improvement	Some need for improvement	Some need for improvement	Some need for improvement

Three major challenges

The assessments identified a number of challenges that need to be addressed to achieve UHC in the area of SRMNCAH. Details are set out in the individual country assessment reports, which make specific recommendations for each country. This synthesis of findings, however, points to three major health systems challenges. The following sections summarize those challenges, each of which includes broad health systems areas, and provide policy recommendations. The intention is to highlight the specific issues around SRMNCAH that need to be addressed as fundamental prerequisites for moving towards UHC.

PHC for SRMNCAH

PHC can meet more than 70% of people’s health needs throughout their lifetime, from health promotion and disease prevention to treatment and management of long-term health conditions.¹⁷ SRMNCAH relies on well functioning PHC systems, giving the nature of services needed for women, children and adolescents.

The assessment revealed the following major challenges at the PHC level to delivering adequately on SRMNCAH; these are, in fact, reflections of overall weaknesses in health systems.

- PHC services are often fragmented. In antenatal care, pregnant women have to see many different providers. Likewise for STIs, many patients are referred to the tertiary level for consultation and diagnosis or choose to pay directly for a complete service at private clinics, which may exclude some groups.

¹⁷ Fast track to strong primary health care. In: WHO/Europe [website]. Copenhagen: WHO Regional Office for Europe; 2019 (<http://www.euro.who.int/en/health-topics/Health-systems/primary-health-care/news/news/2019/5/fast-track-to-strong-primary-health-care>, accessed 20 November 2019).

Provision of contraceptives and services with multiple options for contraception are not universally available. Authorization to perform abortions is restricted to specialist obstetricians and gynaecologists at the hospital level, despite WHO recommendations that abortion services should be provided at the lowest appropriate level of the health care system: even mid-level health workers can be trained to provide safe, early medical abortion without compromising safety up to nine completed weeks of pregnancy.

- The PHC level is often bypassed, and patients go directly to hospitals or private providers.
- Overhospitalization of patients with ambulatory care-sensitive conditions, which could be treated better and more efficiently at the outpatient level, is a major challenge.
- Quality of care is a challenge. Examples include polypharmacy, overuse of antibiotics and overhospitalization of children treated for pneumonia. Mass screenings of children and adolescents – “dispensarization” – are also still implemented in some countries. Some of these are potentially harmful practices and an inefficient way to spend the often limited time and funding available for health care. Perceived contraindications for vaccinations are not always evidence-based, which may delay immunization. Quality of care and services was identified as a main issue in all the countries assessed, and as being a relatively greater challenge for most of the tracer interventions than protocols, scope of services and coverage.

Main reasons for these findings are as follows.

- **Care is often not integrated** at the PHC level: paediatricians and obstetricians often work in primary care with family doctors, but the services are not fully integrated. The role of family doctors vis a vis specialists is not always clear, and in the Shemashko system – which a number of the assessed countries have built their health systems around – traditionally a number of PHC functions for SRMNCAH that could be done by family doctors and in general are typical responsibilities for primary care physicians are still perceived as tasks for specialists.
- **Family doctors are not always skilled** and/or provided with capacity to deliver essential SRMNCAH services, such as IUD insertion and simple STI treatment, causing multiple referrals and fragmentation. This is especially the case when primary care providers have to play a critical role in supporting underserved patients in both rural and urban settings.
- **Nurses and midwives are underused** in delivery of increased levels of health promotion and disease prevention. They could strengthen family doctors’ ability to deliver comprehensive, continuous and rapid services, but are very often not enabled, resourced and supported to apply their full potential.
- **Evidence-based protocols and guidelines for SRMNCAH are not always updated or followed.** Mass screenings (dispensarization) are an example of a non-evidence-based intervention, taking away limited resources that could otherwise have been used at the PHC level. Detection of pre-eclampsia at the PHC level seems suboptimal, and it appears to be underdiagnosed in the majority of the countries.
- **Shortages in the health workforce** are evident at the PHC level. Recruitment and retention of health workers, particularly in rural areas, is seen as a challenge in all the countries. Key reasons are reportedly low salaries and poor working conditions, despite incentive schemes (extra salary, additional training) in some countries to attract health workers to rural areas. In addition, the proportion of specialists (paediatricians and obstetricians) versus general practitioners, depending on the envisioned model of PHC and the distribution of staff at the PHC versus hospital level, is not always optimal.
- **There is a lack of trust in the PHC level.** Patient interviews indicated that, due to referrals to specialists for minor issues and perceived lack of competencies of family physicians, it is sometimes easier to go directly to hospitals, where they can get a full investigation and treatment in one place.
- **Perverse financial incentives are in place.** The PHC level is often funded on a per capita basis, with few incentives to expand treatment at that level. Furthermore, at times financial incentives for hospital admission are in place for both patients and providers. In the Republic of Moldova, for example, drugs

may be free of charge at hospitals but not at the PHC level, meaning that parents prefer their children to be treated at hospitals. Likewise, historical budgeting for hospitals rewards a high bed occupancy rate, creating incentives for the hospital to admit patients.

- **Data are not systematically used for planning.** Data are often reported upwards in the system and used for budgetary and payment purposes, rather than for planning at the PHC level. Limited capacity for data analysis at lower levels was mentioned as a challenge in several countries.

Policy recommendations

The role of the health ministry

- The balance between resources spent on keeping open a large number of hospitals and beds and the need to strengthen PHC, including prevention, should be reviewed.
- The role of family doctors in providing SRMNCAH should be reviewed and strengthened, including an assessment of:
 - skills, competencies, training and supervision/mentoring needs;
 - professional development related to re-certification;
 - incentives for working in rural areas (accommodation, education for children, professional development);
 - incentives/disincentives for providing a core package of SRMNCAH services – currently, referral is the “easy” choice;
 - other factors that may undermine the perception of family doctors and their competencies, including highlighting the health system function from community to family doctor to hospital, and the roles of specialists versus generalists.
- The role of nurses and midwives should be reviewed and strengthened, including an assessment of:
 - training curricula of nurses and midwives in PHC;
 - clear scopes of practice and continuing professional development opportunities, as well as opportunities either to deliver these services generally (screening, management and health promotion) or to go further to specialize or run their own services to deliver advanced services to the population;
 - scope for new and innovative models of care that could improve access and health outcomes.
- Human resources and financing policies should be reviewed to expand the scope of health promotion and prevention, and should include task-shifting to mid-level health professionals (such as midwives and nurses) to assume monitoring, check-ups and provision of basic interventions in SRMNCAH.
- Guidelines/protocols for routine examinations, particularly for women of reproductive age, should be reviewed to ensure that resources, including specialized care, are used for those women in need of treatment rather than for multiple visits for healthy women.
- Collaboration and coordination between family doctors and specialized ambulatory services should be strengthened and an integrated model of care developed to avoid fragmentation and to improve and increase coverage of key SRMNCAH interventions.
- The norms and need for staffing in the area of SRMNCAH at hospital levels should be reviewed, using data from the health management information system, considering the many patients with ambulatory care-sensitive conditions that continue to be treated as inpatients, leading to overhospitalization.
- A major effort should be made to ensure that sex and age disaggregation, at minimum, are done for all reported data in the health information system; information gaps on SRMNCAH in the context of UHC should be reviewed, particularly with regard to data on equity and vulnerable populations.

- Existing data on SRMNCAH status, quality and the performance of health service providers should be used in conjunction with analysis and generation of actionable information for policy-making and programming at all levels.

The role of the WHO Regional Office for Europe

- Frameworks for action, such as the European Framework for Action on Integrated Health Services Delivery¹⁸ – which is aligned with commitments on noncommunicable disease outcomes, women’s health, reproductive health and disease-specific strategies – are already in place. It is therefore important that the Regional Office:
 - provides technical assistance across areas such as noncommunicable diseases, SRMNCAH, disease-specific programmes and health systems programmes, including for reviewing existing PHC models;
 - supports the dissemination and application of guidelines, protocols and tools relevant for PHC in the area of SRMNCAH;
 - reviews and develops evidence-based positions on screenings and check-ups in SRMNCAH.

Health benefit packages

UHC encompasses equity in access to health services, adequate quality of the services to improve health outcomes and protection against financial risk. The SRMNCAH country assessments revealed that several major challenges related to equity need to be addressed.

- High OOP payments are a challenge in all the countries, varying from 21% to 79% as a proportion of current health expenditure. Medicines are a main driver of OOP payments, but informal payments for services were also reported.
- Clients are not always informed about their entitlements within the health benefit package, and accountability mechanisms to establish and monitor those requirements are limited.
- Contraceptives are generally not included and HPV vaccination is not covered in any health benefit packages. Treatment of STIs is often paid fully or partially by patients themselves. Abortion – except in the case of miscarriage or for medical reasons – is not covered in any of the countries.
- Stockouts of supposedly free medicines for chronic conditions were reported in several countries, forcing patients to purchase their own medicines.
- In all countries, access to services is reportedly more limited in rural versus urban areas. Further, certain population groups, such as Roma populations, have lower coverage of interventions, including immunization. Coverage of certain packages, such as sexual and reproductive health for adolescents, is in general very low.

Main reasons for these findings are as follows.

- **Investment in the health sector is low.** Government expenditure on health as both a proportion of total government expenditure and a proportion of GDP are substantially lower in most of the assessed countries than the EU average, leading to relatively small public resources spent on health.
- **The official state health benefit packages are often underfunded.** Despite officially being all-inclusive, covering a wide range of SRMNCAH and other services, this lack of resources leads to rationing and OOP payments.

¹⁸ European Framework for Action on Integrated Health Services Delivery (EFA IHSD). In: WHO/Europe [website]. Copenhagen: WHO Regional Office for Europe; 2019 (<http://www.euro.who.int/en/health-topics/Health-systems/primary-health-care/european-framework-for-action-on-integrated-health-services-delivery-efa-ihsd>, accessed 20 November 2019).

- **Explicit mechanisms to set priorities are limited**, pushing rationing decisions to the provider level via both formal and informal mechanisms. None of the countries have clear and defined criteria or processes for deciding which SRMNCAH and other services should be included in the health benefit packages or subsidized. Furthermore, some interventions are covered by vertical programmes, while others are included in the health benefit packages/insurance schemes, creating a fragmented design of the overall health service system.

Policy recommendations

The role of the health ministry

- Given the limited resources available, benefits and entitlements funded by public sources should be reviewed, with the aim of specifically targeting those most in need (such as poor or socially vulnerable population groups and adolescents).
- Clear criteria and transparent processes should be developed for inclusion of health services, including SRMNCAH in the health benefit package. The content of the package should be clearly communicated to health service providers and the public, and accountability mechanisms should be in place for monitoring. The services included should reflect the epidemiological situation, including health needs and burden of disease, cost–effectiveness associated with treatment/management of the condition, financial burden and fiscal impact and – most importantly – the real needs of women, children, adolescents and other vulnerable groups. Clear institutional frameworks need to be put in place to balance these various considerations as there are no blueprints.
- Population coverage gaps should be reviewed and addressed, especially in countries where entitlement is linked to contribution payments, and particularly with regard to young people, women and marginalized groups such as Roma populations, disabled people, migrants and others, with a view to ensuring that those in need of SRMNCAH services are covered.
- Existing SRMNCAH services and supplies included in health benefit package should be reviewed with regard to their cost–effectiveness, feasibility, affordability, equity dimensions and other relevant parameters, with the aim of achieving progressive realization of universal coverage.

The role of the WHO Regional Office for Europe

- To support Member States to carry out regular monitoring and analysis of health financing, including tracking of public and private expenditure trends and related burdens on households. Such analyses should also lead to better mapping of coverage gaps and to policy recommendations to close such gaps.
- To review current benefit packages with regard to priority-setting methods, methods including explicit criteria for decision-making, institutional arrangements for service delivery and critical aspects of implementation and monitoring and evaluation. Based on this, it should identify possible policy responses to close coverage gaps through better priority-setting and sharing examples of good practice.
- To provide technical assistance with development/updating and setting up of mechanisms for implementation and monitoring of health benefit packages.

Specific SRMNCAH areas and interventions needing more attention

The review of the assessments' evidence on the tracer interventions shows that two – antenatal care and immunization – are performing relatively better in all the assessed countries, with ratings of good practice/little need for improvement or some need for improvement for all the attributes. In contrast, and with a few exceptions, sexual and reproductive health services for adolescents and to a certain extent transport of sick neonates and STIs score poorly in almost all the countries. Management of common childhood conditions shows a more mixed picture.

The two better-performing interventions are generally accepted and uncontroversial, with clear standard guidelines for the provision of the services. They can also be provided on a scheduled basis, and planned and provided in outpatient or outreach settings.

The services that need to be in place on a continuous basis – whenever a patient arrives – perform worse. Transport of sick neonates is a good indicator for the preparedness and responsiveness of the health system, as it requires capacity and skills at primary, secondary and tertiary levels, good collaboration and interaction between the levels and a well functioning referral system, including transport and adequate equipment. The findings show that most countries have challenges in this regard.

Adolescent sexual and reproductive health services and, to a certain extent, treatment of STIs reflect both societal values and health workers' attitudes. People with STIs often face stigma, stereotyping and shame, and adolescent sexual and reproductive health is still controversial in many countries.

Provision of family planning services is a challenge in all assessed countries. Contraceptives – and especially emergency contraceptives – are often not provided free of charge. If they are, the poor quality of those provided makes women prefer to get a prescription and buy them at pharmacies; this is usually costly.

Quality of services was a greater challenge for most of the tracer interventions than protocols, scope of services and coverage. Fragmentation of services, lack of skills and financially perverse incentives at the PHC level are common problems.

Based on the overall assessment findings, two areas require specific attention towards achieving UHC: sexual and reproductive health and neonatal health.

Sexual and reproductive health

Universal access to sexual and reproductive health and rights is linked with sociocultural norms, political and legal realities that need close attention to ensure coverage of the most in-need and marginalized groups. Including a comprehensive range of sexual and reproductive health and rights interventions (preventive, promotive, curative and palliative) in benefits packages may not be straightforward for a number of reasons, including competing interests and demands, sociopolitical realities, financial resources, governance of health systems, service delivery and other health systems constraints. Nevertheless, the progressive realization of the comprehensive range of related interventions, with its key principles including a clear track record of progressive realization and countries' commitment to progress and meeting their obligations in this area, must be a focus.

Sexual and reproductive health is still controversial in many countries and only two of the assessed countries have a relevant strategy in place, despite the Action Plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind¹⁹ and its resolution, adopted by the 66th session of the WHO Regional Committee for Europe in September 2016, encouraging national adaptation. Even when policies are in place, health workers' attitudes towards adolescent sexual and reproductive health and stigmatization of people with STIs at times form barriers to access of comprehensive services.

Adolescent birth rates are higher than the average for the WHO European Region in almost all the countries (some of which have rates 3–4 times higher). Further, maternal and perinatal health outcomes are still not optimal and marriage of girls before the age of 18 years in the assessed countries is relatively common, ranging from 7% to 12%, so the need for implementation of holistic, rights-based and comprehensive sexual and reproductive health strategies and programmes is apparent. Sexual and reproductive health needs to be an integrated

¹⁹ Action Plan for Sexual and Reproductive Health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind. Copenhagen: WHO Regional Office for Europe; 2016 (<http://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health/publications/2016/action-plan-for-sexual-and-reproductive-health-towards-achieving-the-2030-agenda-for-sustainable-development-in-europe-leaving-no-one-behind-2016>, accessed 18 November 2019).

and key part of the UHC agenda, as a prerequisite for achieving universal coverage. According to the Guttmacher–Lancet Commission on Sexual and Reproductive Health and Rights,²⁰ and in line with WHO definitions, an essential package of sexual and reproductive health interventions would include:

- comprehensive sexuality education;
- counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods;
- antenatal, childbirth and postnatal care, including emergency obstetric and newborn care;
- safe abortion services and treatment of complications of unsafe abortion;
- prevention and treatment of HIV and other STIs;
- prevention, detection, immediate services and referrals for cases of sexual and gender-based violence;
- prevention, detection and management of reproductive cancers, especially cervical cancer;
- information, counselling and services for subfertility and infertility;
- information, counselling and services for sexual health and well-being.

Against this background, the findings of the assessments show the following.

- Only one country has mandatory sexuality education in schools. Combined with the absence or scarcity of sexual and reproductive health services for adolescents within the health sector in most of the assessed countries, this leaves adolescents with little support and few ways to access information.
- Protocols and legislation in some of the countries preclude adolescents under 18 years accessing services without parental consent; in others, the legislation on provision of sexual and reproductive health services to adolescents is inconsistent or not being followed.
- Adolescent sexual and reproductive health services are nonexistent or very limited in most of the countries. Large-scale adolescent-friendly health centres have been established in only one country.
- WHO estimates that one in four women in the European Region will experience violence on the basis of gender at one point in their lives. Data are limited and underreported, however, in all countries. Services for victims of gender-based violence are also limited, and mostly provided through NGOs.
- Contraceptives and HPV vaccination are not included in the health benefit packages. Abortion services are also not included – except for miscarriage or for a medical reason – with service availability mainly limited to urban areas and mostly in hospital settings.
- STI services are often fragmented, with referrals to specialists or hospitals; statistics on STIs are poor.
- Cervical cancer screening is not performed at the PHC level in five of the countries assessed, and is not included in the health benefit package in two of the countries.

Policy recommendations

The role of the health ministry

- The current status of sexual and reproductive health should be reviewed, based on the findings and recommendations of the assessment reports and other relevant information. This should include an in-depth analysis from a gender and social equity perspective of who is excluded from coverage and who bears the burden of financial risks and for what services.

²⁰ Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R et al. Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. *Lancet*. 2018;391(10140):2642–92. doi:10.1016/S0140-6736(18)30293-9.

- To consider developing and/or updating strategies and plans in line with the WHO Action plan for sexual and reproductive health in a consultative way involving all relevant stakeholders, including educational institutions and the school sector.
- Violence against women and sexual abuse should be addressed at the PHC level following the WHO guidelines for responding to intimate-partner and sexual violence against women.²¹
- To establish a track record for progressive realization of sexual and reproductive health and rights, including setting policy targets for closing equity gaps – for example, between geographical areas and population groups. This should present all sexual and reproductive health data disaggregated for sex, age, geographical location, ethnicity and wealth, and monitor the data over time to ascertain that equity gaps are closing.
- A review of beneficiaries of free services should be undertaken to ensure that pregnant women, socially vulnerable young women and adolescent girls are a priority for government-funded services. It should be ensured that when vertical programmes covering vulnerable groups cease to function, these functions are included in insurance or benefit packages.
- Sex- and age-disaggregated indicators that are acceptable, feasible and practical for monitoring national action plans should be identified and data produced accordingly.
- Information systems for monitoring progress towards achieving agreed targets, including the reduction of inequities, should be strengthened and upgraded.

The role of the WHO Regional Office for Europe

- To provide technical assistance with evaluating implementation of the current or completed plan of action on sexual and reproductive health and with conducting a situation analysis of present needs.
- To support integrated health services delivery, including sexual and reproductive health in line with the European Framework for Action on Integrated Health Services Delivery.²²
- Collaboration and coherence among relevant United Nations agencies at national and regional levels and close cooperation with partners, including bilateral donor and development agencies, should be strengthened.
- To disseminate evidence-based guidelines and tools, and assist countries with their national adaptation.

²¹ Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (<https://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>, accessed 20 November 2019).

²² European Framework for Action on Integrated Health Services Delivery (EFFA IHSD). In: WHO/Europe [website]. Copenhagen: WHO Regional Office for Europe; 2019 (<http://www.euro.who.int/en/health-topics/Health-systems/primary-health-care/european-framework-for-action-on-integrated-health-services-delivery-ffa-ihsd>, accessed 20 November 2019).

Neonatal health

In 2018, 47% of deaths among children under 5 years globally were of neonates. Almost all countries assessed had a higher neonatal mortality than the WHO European regional average of 4.6/1000.²³ Good quality of care at the time of birth and during the neonatal period is essential not only for neonatal survival but to ensure that the baby thrives with adequate growth and development.

Components of a neonatal care programme include essential newborn care for all babies and special or intensive care for preterm and sick neonates. Hospitals should support exclusive breastfeeding, the baby-friendly hospital initiative and nonseparation of mothers and babies. Strong evidence from high-income countries shows that the regionalization of maternal and neonatal care and availability of neonatal intensive care has improved outcomes for high-risk infants born either preterm or with serious medical or surgical conditions.²⁴ Regionalization of care establishes systems designating where infants are born or transferred according to the level of care they need at birth. Hospitals are assigned risk-appropriate levels and efforts are made to ensure that high-risk infants are born in facilities with appropriate technology and specialist health providers. Newborn transport services are required for safe and efficient transfers to and from referral neonatal care facilities, using experienced and qualified personnel and specialist transport teams and vehicles.

The findings of the assessments show the following.

- Only one country has a national functioning neonatal transport service.
- Most countries have introduced regionalization of perinatal care, but services are fragmented in relation to human and material resources at specific facilities.
- Most countries have patient transport systems but legislation does not cover neonatal transport.
- Functional neonatal transport services, specific neonatal transport vehicles or neonatal transport incubators are generally available only in capital cities.
- No helicopters or planes are available for neonatal transport in most countries.
- Specific protocols for the mechanism and organization of neonatal transport are generally unavailable.
- No systematic approach to neonatal transport is in place to guarantee equal access to intensive care when required.
- Clinical protocols for management and monitoring of preterm and sick neonates in health facilities and during transport are not always available; when available, they are not always evidence-based.
- Quality of neonatal transport is limited, with most staff transporting sick neonates not specifically trained or not trained in neonatal-specific transport equipment. Further, some equipment is outdated.
- Significant delays in transport were identified, particularly from villages to higher-level facilities.
- Systematic monitoring of transport times and status of neonates on arrival at referral facilities is generally lacking.
- Families experience OOP payments – often informal – and need to make private arrangements to transport sick neonates to higher-level facilities.
- Neonatal interventions are only available at the hospital level and surfactant is only available at the tertiary level.

²³ Neonatal mortality: situation. In: WHO Global Health Observatory (GHO) data [database]. Geneva: World Health Organization; 2019 (https://www.who.int/gho/child_health/mortality/neonatal/en/, accessed 4 September 2019).

²⁴ American Academy of Pediatrics Committee on Fetus And Newborn. Policy statement: levels of neonatal care. *Pediatrics*. 2012; 130(3): 587–97. doi:10.1542/peds.2012-1999.

Policy recommendations

The role of the health ministry

- To review the current status of neonatal transport, based on the findings and recommendations of the assessment reports and other relevant information.
- Neonatal transport policies and strategies should be developed and/or updated to ensure the presence of a national or subnational integrated newborn network with clear referral pathways; a coordinating referral centre providing clinical management support; protocols and guidelines; documentation of required neonatal transport drugs, supplies and equipment; and necessary skills and competencies of specialist staff conducting neonatal transport.
- Evidence-based neonatal clinical guidelines should be consistent with WHO's recommendations and other international guidelines should be appropriately developed, implemented and monitored at health facilities at all levels.
- Neonatal transport input, output/process and outcome indicators should be developed, including disaggregation for sex, age, geographical location, ethnicity and wealth, and the data monitored over time to ascertain that equity gaps are closing.
- Information systems necessary for monitoring progress in neonatal health towards achieving agreed targets, including the reduction of inequities, should be strengthened and upgraded.

The role of the WHO Regional Office for Europe

- To provide technical assistance with developing and implementing an effective neonatal transport system, based on current evidence and situation analysis of present needs.
- Collaboration and coordination with relevant United Nations agencies at national and regional levels and close cooperation with partners, including bilateral donor and development agencies, should be strengthened.
- Evidence-based neonatal guidelines and tools should be disseminated and countries assisted with their national adaptation.

Conclusions and way forward

This synthesis report identifies health system barriers to UHC for SRMNCAH, including from a gender and rights perspective. By drawing attention to three major challenges and making policy recommendations for them, the report highlights specific issues to address.

The challenges and recommendations cut across various aspects of the health system and involve other sectors. The problems encountered are thus likely to affect the system beyond the scope of this assessment, making it a marker of overall health system functions. The recommendations are intended to contribute to efforts in accelerating progress towards UHC.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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