28 Annex - Consumer and health protection

219. STRATEGY FOR PRESERVING AND IMPROVEMENT OF REPRODUCTIVE HEALTH

THE GOVERNMENT OF THE REPUBLIC OF MONTENEGRO

MINISTRY OF HEALTH

REPUBLIC COMISSION FOR REPRODUCTIVE HEALTH

STRATEGY
FOR PRESERVATION AND PROMOTION
OF REPRODUCTIVE HEALTH

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INTRODUCTION

United Nations' Millennium Development Goals (2000) stipulated mother and child health care as a global goal in providing social justice by achieving universal principles of human rights. All eight millennium goals are directly or indirectly linked with mothers' and children health, and goals number 4 and 5 are directly linked with infant mortality reduction and improvement of mothers' health. The loss of more than 10 million children in the age of up to one year, each year, triggered a widespread international intervention to reduce maternal and infant mortality rates.

Health of mothers and children are the greatest challenges of health care system improvement, as a part of the public health system through maintenance and improvement of health care. The Assembly of the World Health Organization (WHO, 57th Session, 2004) adopted the ''Global Strategy for Reproductive Health'' with the scope of accelerating the progress in achieving millennium development goals, aimed towards improvement of sexual and reproductive health of every country's population. The goal of the Strategy is to improve global reduction of maternal and prenatal mortality and the death rate of mothers and children. On a global level, general attitudes from the WHO Declaration were determined – Health for all, through the conclusions of the international ''Conference on Population and Development'' (ICPD, Cairo 1994), 'The Fourth World Conference on Women (Beijing, 1995), which all countries are obliged to obey.

The World Health Organization recommends all governments of countries in the European region, interagency and non-governmental organizations and institutions to give precedence to attitudes and policies related to health promotion of mothers and children, within health policies. WHO Resolution obliges member countries to develop and strengthen their programmes for reproductive and sexual health in the following manner:

1. To estimate their needs in the context of reproductive health and develop long-term guidelines, guided by the WHO principles, with particular emphasis on gender equality aimed at those who will benefit from it. All activities need to be placed in the framework of internationally recognized human rights.
2. To strengthen health workers capacity who would recognize the need for reproductive health of individuals in a humane, noble and civilised manner, paying particular attention to age (youth, adolescents), improve the content of the course and methodology for training health workers in the area of reproductive health and human sexuality, provide support and instructions to individuals, parents, teachers and other stakeholders in these areas.
3. To monitor and evaluate the process, quality and efficiency of the reproductive health programme as part of regulatory monitoring which represents a progress for all health care strategies.

The Strategy of reproductive health is an area of particular concern of the World Health Organization within the European region. Reasons for action of WHO is the existence of non-acceptable discrepancies in the status of reproductive health among the population in Western, Central and Eastern Europe. In Western European countries mortality rate is under 2 per 1000 live births. That is why improvements in the area of reproductive health are so significant within the scope of the European programme – Solidarity for Health in the European region. Processes of social and economic transition have resulted in higher unemployment, poverty, disintegration of social networks and countries facing transition problems are cutting their budgets for social and health sector, which has a predominant effect on the health of the population, particularly on vulnerable groups, among which children and mothers are most significant. Transition countries are at the same time facing problems with health care of adolescents, sexual abuse, reproductive health care of refugees and displaced persons and other groups, which need to get special attention of health care and other authorities throughout Europe. That is why it is stressed out that national strategies for reproductive health improvement need to be elaborated and compatible with the adopted documents of the World Health Organization – European region in each of the fifty-two member countries from Europe.

Bearing in mind the stated recommendations, resolutions and attitudes of all international subjects, there is a necessity to create framework for policy and strategy development, for different health programmes, in order to bring them into harmony and provide for better regional cooperation on all levels, all with the scope of preserving and promoting health. That is why, apart from the Strategy

for Health Development as a global document, special strategies for priority areas of public health care are developed, which include reproductive health. Health promotion of mothers and children is a priority in all strategic documents of the Government of Montenegro.

Strategy for Preservation and Promotion of Reproductive Health has the following goals:

1. **provide for implementation of health policy goals, particularly in the area of health care of pregnant women and infants through implementation of preventive measures;**
2. **reduce prenatal infant mortality by 50%;**
3. **provide for health improvement in the area of reproductive health to all population, including sexual health; and**
4. **reduce differences and discrepancies in reproductive health.**

1. OBJECTIVES AND TARGETS OF REPRODUCTIVE HEALTH

World Health Organization (WHO, 1994) defines reproductive health as the state of health referring to reproductive relations, functions and systems in all stages of life. The content of the definition implies that people should be are capable of leading responsible, satisfactory and safe life and have the freedom of choice to decide whether, when and how many children they would like to have. It is the implicit right of men and women to be informed about this, to have access to safe, efficient, available and acceptable methods of fertility regulation, according to personal choice, and to be provided with adequate health care services which should provide safe pregnancy and birth of a healthy and desired child.

Internationally recognized definition of reproductive health elaborated during the conference (ICPD, Cairo 1994) also includes the area of sexual health (responsible, satisfactory and safe sexual life); reproductive freedoms (access to information, methods and services) and safe motherhood (safe pregnancy, birth of a healthy child).

In the context of elaborated definitions there is a definition of sexual health, which implies a positive approach to human sexuality in the scope of sexual health care based on positive grounds, which advances life and personal relations (WHO, 1975). It is considered that sexual health is an integration of somatic, emotional, intellectual and social aspects of sexuality in a manner which positively enrich and increase personal relations, communication, and love.

The area of reproductive health improvement in Montenegro, according to recommendations of the World Health Organization, for the period up to 2010, includes the following objectives and targets:

2.1. Area of decision making regarding reproductive health;

2.2. Area of safe maternity;

2.3. Area of sexual abuse and violence;

2.4. Are of STD/HIV control;

2.5. Women trafficking;

2.6. Breast cancer;

2.7. Area of sexual and reproductive health of adolescents;

2.8. Relations with refugees and displaced persons;

2.9. Relations with migrating population;

2.10. Relations with the elderly.

2.1. Area of decision making regarding reproductive health

2.1.1. Objective 1

Increase of information sharing to individuals and couples regarding their right to make a free choice about the number and time of having children, in order to promote the goal of having only desired children.

Manner of implementation:

- Harmonization of legislation from this area with internationally recognized documents on reproductive health care;
- Incorporation of the concept of reproductive rights into school curricula, and into extracurricular activities of youth;
- 75% of population needs to be familiarized with methodologies of family planning and contraception;
- Institutions providing services (such as deliberate abortions) need to have counselling room on contraception; and
- Twofold protection (from infections and pregnancy) needs to be adopted and practiced by those exposed to risk.

2.1.2. Objective 2

Reduction of deliberate abortions

Manner of implementation:

- Limit abortion as alternative to family planning;
- Include family planning into primary health care programs; and
- Remove legal obstacles for the choice of contraceptive method.

2.1.3. Objective 3

Improve access to contraceptive services

Manner of implementation:

- Increase the number of contraception means within positive list of medicines;
- Make contraception services an integral part of the benefits package in primary health care;
- Rules providing for reliability and anonymity of contraceptive services need to be obeyed and adopted in practice; and
- Create health care programmes which would guarantee that age (adolescents), sex, personal status, ethnic origin, language proficiency, amount of contributions and other criteria, do not pose an obstacle for providing services to those who need them.

2.1.4. Objective 4

Extend the scope of contraceptive options

Manner of implementation:

- Every chosen gynaecologist or service needs to be capable to offer at least three different contraceptive methods;
- Chosen gynaecologists and gynaecology services need to offer the use of emergency contraception;
- Contraindications need to be known related to the use of any contraception method.

2.1.5. Objective 5

Involvement of male gender

Manner of implementation:

- Legal barriers for sterilisation of men need to be removed;
- Provide for medical treatment of increased male infertility which is on the rise.

2.2. Area of safe maternity

2.2.1. Objective 1

Reduce maternal mortality and morbidity rate

Manner of implementation:

- Low rate (10-20), reduction by 20% during a five-year period;
- Medium rate (21-40), reduction by 30%;
- High rate (more than 40) reduction se by 40%;
- Reduce morbidity and mortality rate mothers as a consequence of deliberate abortion;
- Increase the proportion of pregnant women whose pregnancy is monitored by a gynaecologist, at least to 98%;
- Increase the proportion of labours attended by medical professionals to at least 98%;
- Reduce prevalence of anaemia with pregnant women;
- Provide for equal access of health care to women, particularly in primary health care;
- Provide for complete care for women at the primary level by organizing three regional centres for reproductive health, as follows: Northern, Central and Southern region; and
- Regional centres need to include all ten areas of reproductive health.

2.2.2. Objective 2

Reduce prenatal and neonatal mortality rate

Manner of implementation:

- Low rates (less than 10) need to be reduced by 20%;
- Medium rates (10-19) need to be reduced by 30%;
- High rates (20 and higher) need to be reduced by 40%;
- Increase the percentage of breastfed babies up to 6 months of age to 60%;
- Provide for organization of work in every obstetric ward for ‘baby friendly’ operation;
- Increase the proportion of population familiar with basic problems related to pregnancy and birth.

2.3. Area of sexual abuse and violence

2.3.1. Objective 1

Reduce sexual abuse and violence and their consequences.

Manner of implementation:

- Implement measures for preventing violence against women stipulated by national documents;
- Create a database on sexual abuse and violence;
- Establish an institution for female victims of violence where they can get help and protection; and
- Provide for adequate mechanisms for sanctioning violence against women.

2.4. Area of control of sexually transmitted diseases

2.4.1. Objective 1

Reduce the incidence and prevalence of sexually transmitted diseases

Manner of implementation:

- Reduce the incidence of syphilis;
- Reduce the prevalence of curable sexually transmitted diseases to less than 10% of the population;
- Provide for effective treatment of at least 80% cases of sexually transmitted diseases.

2.4.2. Objective 2

Reduce the incidence and prevalence of HIV/AIDS

Manner of implementation:

- Consistently apply measures stipulated by the Strategy for HIV/AIDS Prevention;
- Provide for twofold protection of women by using condoms and contraceptives with at least 30% of the population;
- HIV testing is obligatory for all pregnant women during antenatal care; and
- Reduce the incidence of HIV transmittance from mother to child by treating HIV-positive pregnant women.

2.4.3. Objective 3

Reduce the incidence and prevalence of cervix cancer

Manner of implementation:

- Create a screening programme for early detection of cervix cancer;
- Make at least 90% of female population use preventive services at the primary health care level, within the scope of their rights;
- Provide for modern diagnostic methods for early detection of cancer in all health centres.

2.4.4. Objective 4

Improve the health of the whole population regarding sexually transmitted diseases and HIV/AIDS

Manner of implementation:

- Include training courses on sexually transmitted diseases and HIV/AIDS into educational curricula;
- Provide for youth education for the programmes on prevention of these diseases;
- Include the media into activities of reproductive health promotion.

2.5. Area of women trafficking

2.5.1. Objective 1

Increase measures for prevention of trafficking and provide for protection of trafficking victims

Manner of implementation:

- Implement measures of the National Action Plan for the struggle against human trafficking;
- Organize campaigns for raising public awareness on trafficking;
- Protect trafficking victims.

2.6. Breast cancer

2.6.1. Objective 1

Promote and support projects of screening and early detection of breast cancer and engage in extend knowledge among women by self-exams.

Manner of implementation:

- Make at least 90% of women from the risk group carry out a checkup once a year;
- Promote mammography for diagnostic purposes;
- Provide for standardization of diagnostic equipment in health centres and in regional centres for reproductive health;
- Provide for screening of risk groups and possibility for determining breast pathology; and
- Develop training programmes for women.

2.7. Area of sexual and reproductive health of adolescents

2.7.1. Objective 1

Educate adolescents about all areas of sexual and reproductive health

Manner of implementation:

- Incorporate education on sexual and reproductive health into secondary school curricula;
- Develop educational programmes for peer education on sexual and reproductive health for the youth outside schools;

2.7.2. Objective 2

Provide for easy access of health services for youth

Manner of implementation:

- Establish youth centres – YFS (Youth Friendly Services) for each 100,000 users and youth counselling units in all health centres;
- Services for youth need to be reliable and adapted to serve the youth including psychological support within the scope of health services;
- Actively include young people in all educational programmes related to sexual and reproductive health improvement.

2.7.3. Objective 3

Reduce undesired pregnancies and sexually transmitted diseases among youth

Manner of implementation:

- It is necessary that at least 75% of youth use protection against pregnancy and sexually transmitted diseases during their first sexual intercourse;
- Reduce pregnancy rate among teenagers by at least 30% of available data;
- Provide for better recordkeeping related to undesired pregnancies in all health institutions.

2.8. Area of refugees and displaced persons

2.8.1. Objective 1

Protection of reproductive health of refugees

Manner of implementation:

- Provide reproductive health services to refugee population according to rights stipulated by the benefits package and in all emergency cases, including medicines and contraceptive method;
- Organize counselling on reproductive health and sexual abuse and on all types of violence, particularly to Roma population in refugee camps.

2.9. Area of migrants

2.9.1. Objective 1

Reduce discrepancies in providing measures of reproductive health care between migrant and resident population

Manner of implementation:

- Organize the use of services for reproductive health care regardless of religious, racial, cultural or language barriers;
- Migrant communities need to be informed in an adequate manner about their right to health insurance and about the organization of the health care system of the country where they currently reside, and about the ways of attaining health care.

2.10. Area of health care for the elderly

2.10.1. Objective 1

Improve sexual health of the elderly

Manner of implementation:

- Inform men and women about emotional, physical, hormone changes during the aging process and provide prevention of complications related to this process;
- Provide privileged treatment to groups of poor social status when dealing with complications resulting from hormone changes.

3. ANALYSIS OF REPRODUCTIVE HEALTH OF THE POPULATION

Based on 2003 Census results, out of the total number of 620,145 inhabitants, women population totals 314,920 inhabitants (Montstat, 2004). Out of the total number of women population fertile women population amounted to 25.28% of the total population of Montenegro, or 156,786 women aged between 15 and 49, which represents an optimal reproductive age. High proportion of women population and its significance in the overall health of population require special activities of health services towards improvement of reproductive health.

Health care of women, as a part of reproductive health care, is provided at primary health care level in 24 organizational units of health centres, seven maternity wards of general hospitals and Maternity Clinic within the Clinical Centre. At the same time, part of this health care is provided in 11 private outpatient clinics.

During 2003, the total number of visits to women clinics within health centres amounted 91,300 visits, visits to counselling service amounted to 3,800 and house calls amounted to 21,300.

Compared to previous years, the number of visits to organizational units of public health institutions has a downward trend, which is a result of smaller number of pregnancies and labours.

No. of doctor's visits in 1993	No. of doctor's visits in 2002	Index 02/93	Daily visits average in 1993	Daily visits average in 2002	Index 02/93
144,000	**124,700**	**91.1**	**26.8 visits**	**15.2 visits**	**56.7**

Health care at the primary level was provided by 80 health workers out of which 33 were specialists in gynaecology. The greatest number of visits was made by women age between 20 and 29: 11,608, and those aged between 30 and 39 made 11,405 visits. The number of visits to counselling services for pregnant women in 2003 was 25,500.

Number of patients treated in hospitals in 2003

Hospital	Discharged patients	Proportion of treated patients
GH Bar	1297	10.31
GH Berane	1597	12.69
GH Bijelo Polje	1079	8.58
GH Kotor	802	6.37
GH Nikšič	1727	13.73
GH Plevlja	637	5.06
GH Cetinje	758	6.03
Clinical Centre	4683	38.66

Hospital maternity wards have 324 beds, or 0.58 beds per 1000 inhabitants. The number of cured female patients suffering from diseases and patients in childbirth amounted to 11,084 in 2003. Health care at this level was provided by 41 specialists in gynaecology, seven resident doctors and 184 medical technicians.

According to vital statistic indicators in Montenegro in 2003:

- **Total number of live births – 8,345**
- **Total number of live births, male – 4,350**
- **Total number of live births, female – 3,995**
- **Total fertility rate – 1.52**

Based on health statistics data, the number of the children that died between 0 and 6 days was 43, and the number of those that died between 0 and 6 days (body weight 1000 grams and more) was 42.

In 2003 there were no records of maternal deaths according to clinical data.

Perinatal, neonatal and post-neonatal mortality rate of infants in Europe in 1999 and in Montenegro in 2001 and 2002[1]

[1] Source: Health for all Database, WHO, Copenhagen and the Institute for Public Health of the Republic of Montenegro (data for Montenegro)

	Infant mortality rate		
	Perinatal	Neonatal	Post-neonatal
Europe	5.42	3.88	2.29
European Union	3.10	3.06	1.64
Montenegro (2001)	13.51	11.2	4.52
Montenegro (2002)	10.2	8.2	2.8

In comparison to European countries Montenegro has very high infant mortality rates. Infant mortality rate is an indicator affected by economic, social and health conditions. Consequences of a multi-decade crisis have left a trace in high infant mortality rates. After the year 2000 mortality rate has a downward trend, which suggests a positive trend in health care of mothers and children.

The highest number of dead infants is in the period from 0 to 6 days (first week of life), which is extremely high in comparison to the European average.

Outpatient morbidity

Overview of illnesses and conditions related to pregnancies, births and confinements in Montenegro in 2003

Diagnoses	Codes – MKB Code ICD-10	Number of cases
Abortus spontaneous	003	274
Abortus medicalis	004	1088
Other pregnancies with miscarriage	002,005-008	97
High blood pressure during pregnancy, during and after childbirth	010-016	230
Premature placenta separation, low seated placenta and prenatal bleeding	044-046	35
Pregnancy concerns regarding sex of the infant and the amnion cavity	030-043,047,048	739
Difficult birth	064-066	19
Haemorrhage post partum	072	32
Other complications of pregnancies and birth	020-029,060-063 067-071, 073-075,081-084	1965
Partus spontaneous simplex	080	2454
Complications of confinement and other conditions	085-099	751

Availability of data on reproductive health in Montenegro is insufficient since there are no adequate protocols. There are discrepancies in criteria for tracking indicators on reproductive health. Official health care statistics records episodes in treatment, therefore a true picture about the health condition of an individual is impossible to obtain, or of quality health indicators in this area. For these reasons and for the needs of the Strategy, a research was conducted with the application of a survey method, which encompasses relevant parameters for condition evaluation.

3.1. RESEARCH ANALYSIS

In order to analyse problems related to reproductive health, a research involving a sample of 697 women was conducted in four cities: Nikšić, Pljevlja, Andrijevica, and Bijelo Polje.

The age of respondents ranged between 14 and 16 years of age, as follows: 14 to 18 years – 39.7%, 19 to 25 years – 13.1%, 26 to 35 years – 19.2%, 36 to 49 years – 23%, and 50 years and over – 5%. Out of 697 respondents 47.1% were single, 47.6% were married, 4% were divorced and 1.1% were widows.

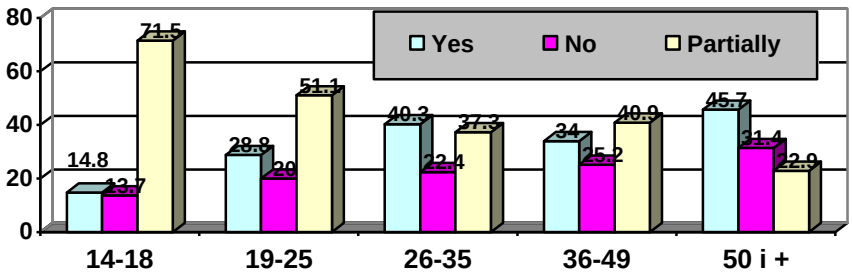
Survey results:

- 68.9% of respondents answered positively the question on whether they were familiar with the term reproductive health?
- As for the question asking about the place where they get information on reproductive health, 27.3% of respondents did not answer, 30.6% answered that they get it at the women clinic (health centres), 11.9% answered that they get them from friends, 15.4% answered that they get them from the Internet and from magazines, and 14.9% answered that they get them from other sources.
- As for the question asking when a gynaecology exam should be done, 41% of respondents answered that it should be done when necessary, 43.3% answered that it should be done once a year, only 2.5% answered that it should be done once in two years or once in five years, and 11.9% answered that it should be done when there are health problems.
- Regarding the use of contraceptive method, the following results were obtained:

  - 13.9% used a condom;
  - 8.2% used an intrauterine contraceptive device (IUCD);
  - 4.7% used contraceptive pills;
  - 6.6% used some other contraceptive method;
  - 20.5% uses other methods.

- As for the question what is the optimum time for bearing a child, 94.5% of respondents thought that it is the age from 21-30 years and only 1.9% thought that it is the age from 15-20 years. On the other hand, 3.4% of respondents thought that it is be the age from 31-45 years.
- 27.3% of respondents thought that men are sufficiently involved in family planning, 19.5% of respondents thought that men are not sufficiently involved in family planning and more than half of the respondents, 51.9% thought that men are just partially involved in family planning.

Opinions per age group on the issue whether men are sufficiently involved in family planning, shown in percentage

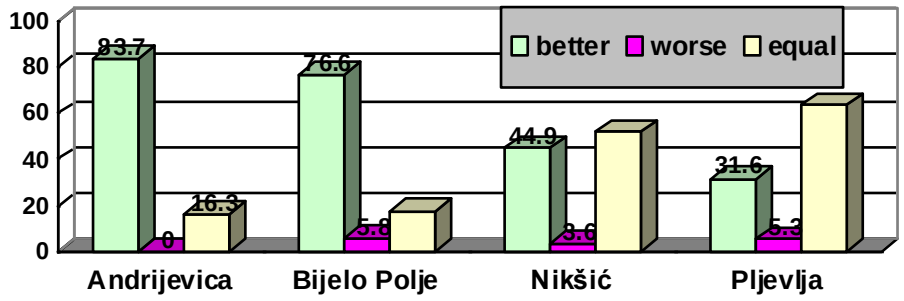


- Regarding the issue of availability of women health care, 21.8% of respondents answered that they wait approximately 10 minutes for a gynaecology checkup, 31% answered that they wait approximately half an hour, and 19.5% answered that they wait approximately for an hour and longer. Regarding the possibility of performing a checkup in one day 44.8% of

respondents answered that it is possible, and 30.1% answered that a complete checkup cannot be performed in one day.

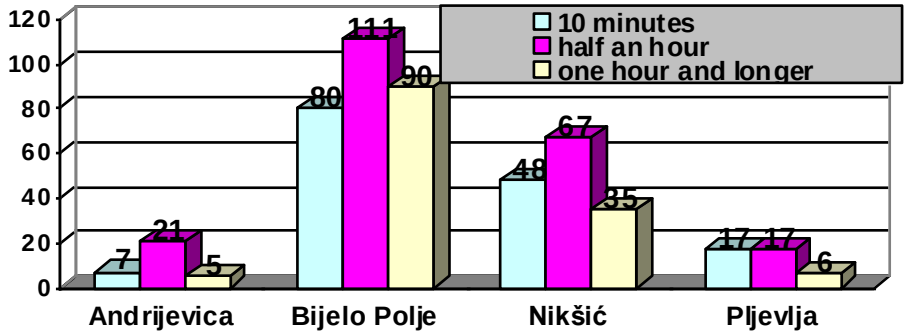
- 22.8% of respondents stated that they feel uncomfortable being seen waiting in front of a gynaecology clinic, and 54.5% answered that they do not mind being seen in front of a gynaecology clinic.
- 51.5% of respondents stated they are afraid/feel uncomfortable when visiting a gynaecologist, whereas only 27.8% of respondents stated they have no fear/do not feel uncomfortable.
- 63.3% of respondents informs some family member of their intention to visit a gynaecologist (16.5% of respondents inform no one and 20.2% did not provide an answer).
- Attitudes towards sexual behaviour of youth are reflected in the opinion that 79.8% of respondents consider that young people begin having sexual intercourse too early and only 16.2% of respondents consider that young people begin with their sexual relations on time.
- 72.3% of respondents believe that young people are not sufficiently informed before having their first sexual intercourse, whereas only 25% consider they are.
- 23.5% of respondents got their first information about sexuality and sexual relationships from their mothers, 1.4% from their fathers, 15.8% from their female friends, 1.4% from their male friends, 5.6% from their boyfriends, and as many as 27.4% from magazines, 6.2% in schools and 12.2 from other sources.
- 49.9% of respondents stated that they were able to find out in primary school everything related to menstruation, puberty, sexual development (48% stated that they were not able to do so), whereas a slightly higher percentage of respondents, 61.5% stated that they were able to come by these information in secondary school (35.3% said that they were not able to do so).
- Only 26.4% of respondents stated that they have been at women's general checkup (70.6% stated they have never been subjected to one), and proportion of women per age group who have undergone a general checkup at any time in their life is quite balanced (approximately one third of the women in all age groups has undergone a general women's checkup, the only group that does not really fall in with others is the youngest age group with 14-18 years of age, where only one fifth of young respondents has undergone a general checkup).
- It is astonishing that as many as 81.5% of respondents have never done a Pap test, whereas only one tenth (9.6%) did this test a year ago, 3.2% two years ago and 4.6% three years ago. Out of 195 respondents older than 35 years, 115 (58.9%) have never done this test and only 34 (17.4%) have done this test a year ago.
- 88.2% of respondents have never done a mammography checkup, 4.7% did it a year ago, 1.9% did it two years ago, and 3.2 did it three years ago (these findings are a result of respondents' age, since 72% of respondents were younger than 35 years). Out of 195 respondents older than 35 years, 149 (76.4%) have never done a mammography checkup, and only 14 (7%) did this checkup a year ago.
- It is disturbing to find out that 42.6% of respondents have never done gynaecology exam whereas 35.3% of respondents have done it a year ago, 5.9% have done it two years ago and 13.3% have done it three or more years ago.
- 53.7% of respondents have never given birth, 9.9% have given birth to one child, 16.5% have given birth to two children and 19.9% have given birth to three and more children.
- In the same group of women 86.2% have never had a deliberate abortion, 5.7% have had 1, 4.3% have had 2, and 3.3% have had 3 or more deliberate abortions.
- In the same group of women 83.8% have never had a miscarriage, 10.8% have had 1, 3.9% have had 2 and 1.6% have had 3 or more incidental miscarriages.
- 61.3% of respondents feels that the quality of services in private clinics is better compared to state-owned clinics, 25.1% of respondents consider the quality equal, and only 4.4% considers that it is even worse.

Opinions on quality discrepancies between private and state-owned clinics in municipalities expressed in percentages

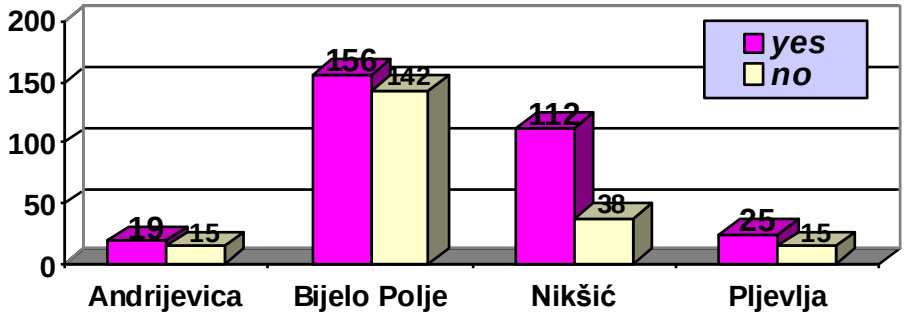


- **Availability of gynaecology services in municipalities**

How long do you wait for a gynaecology checkup?



Do you manage to perform a complete gynaecology checkup in one day?



3.2. REPRODUCTIVE HEALTH INDICATORS

The importance of tracking reproductive health indicators is extremely high, particularly if we bear in mind that goals of promoting health and health status need to be monitored and analyzed in all areas in an objective and standardized manner.

Because of inadequate data tracking of official health statistics, an analysis of necessary indicators that were available, and those which are not monitored, was drafted for the needs of this strategy.

	Indicator	Definition	Comment	Source	2000	2001	2002	2003	2004

1	Maternal mortality rate	Number of deceased women whose cause of death was related to pregnancy and childbirth, during pregnancy or 42 days after birth per 100,000 live births in one year.	Calculation of this indicator is not recommended where population is less than 500,000 or slightly above (also refers to us), since it gives a distorted picture. My recommendation is **Number of deceased women whose cause of death was related to …**	Institute of Public Health of Montenegro	0	2	0		
2	Maternal mortality cause by deliberate abortions		No data available						
3	Prevalence of reliable contraceptive method	Percentage of women aged between 15-49 who use (or whose partners use) some form of reliable contraceptive method (contraceptive pill, intrauterine contraceptive device, local chemical agents, condom, diaphragm)	No routine statistic data available. Independent research needed.	UNICEF, Multiple indicator cluster survey on health condition and behaviour of mothers and children, 2000.	30.7				
4	Anaemia prevalence during pregnancy.		No data available						
5	Perinatal mortality rate	The sum of stillborn infants and infants who died in the first seven days upon birth, divided by total live births (live births + stillborn) * 1000		MONSTAT, Statistical yearbook, 2003			10.76		
6	Neonatal mortality rate	Number of infants who died up to 28 days upon birth, per 1000 live births		MONSTAT, Statistical yearbook, 2003			8.12		
7	Syphilis incidence	The number of reported syphilis A cases 50 – A 53		Institute of Public health, Statistical yearbook, 2002 on Population Health and Health Care in Montenegro		2	4		
8	HIV/AIDS incidence	Until now in 2005, 4 newly recorded		Institute for Public Health, Epidemiology				6	2

		cases		centre, 2005					
9	HIV/AIDS prevalence								31
10	Incidence of cervix cancer	The number of registered cases in outpatient service in 2003 was 138, and inpatient services treated 83 women		Institute of Institute of Public health, Statistical yearbook, 2002 on Population Health and Health Care in Montenegro, Centre for Statistics and Information Systems					
11	Prevalence of cervix cancer		Refers at the number of women diagnosed with: *Neoplasma malignum cervics uteri C53* registered in outpatient services	Institute of Public health, Statistical yearbook, 2002 on Population Health and Health Care in Montenegro			111		
12	Incidence and prevalence of STI		No data available						
13	Pregnancy rate among adolescent girls		No data available, but we can take a proxy indicator. **The number of live births by mothers aged between 15-19** or **Specific fertility ratio of women aged between 15-19**			19.2	422		
14	Total fertility rate	Average number of live births per woman at the end of her childbearing period		UNICEF, National report implementation of the World Summit for Children, 2001	1.87 (1998)				
15	Average fertility rate	Number of live births, regardless of the mother's age, per 1000 women in childbearing period (15-44)	Routine statistical data	MONSTAT, Statistical yearbook 2003		52.6			
16	Specific fertility rate of women aged between15-19	Number of live birth by adolescents aged between15-19 per 1000 adolescents aged between 15-19	Routine statistical data	MONSTAT, Statistical yearbook 2003		19.2			
17	Contraception prevalence	Percentage of women aged between15-49 who use (or whose	No routine statistical data. available Individual	UNICEF, Multiple indicator cluster survey	52.7				

		partners use) any form of contraception	research required.	on health condition and behaviour of mothers and children, 2000.					
18	Prevalence of children with low body weight at birth (below 2500g)	Percentage of live births with body weight inferior to 2500 grams.	Routine health statistics						
19	Percentage of obstetric and gynaecological admissions related to genitals injury		No data available						
20	Percentage of receiving for the reason of abortion		No data available						
21	Prevalence of sterile women		Refers to the number of women diagnosed with *Sterilitas feminae* N97 registered in outpatient services	Institute of Public health, Statistical yearbook, 2002 on Population Health and Health Care in Montenegro			648		
22	Prevalence of urethritis with men		No data						
23	Prevalence of HIV with pregnant women	The number of registered HIV cases + pregnancy	No registered patients	Institute of Public Health			0		

3.3. EVALUATION OF CURRENT SITUATION

Further to presented data in the area of reproductive health care in Montenegro in recent period, the following evaluation may be given:

1. Total capacities for providing services in the area of reproductive health care are developed at primary, secondary and tertiary level of health care with optimum capacities. Surveys on health care accessibility indicate a high level of services provision, on the same day, after checking with the health service.
2. In the area of primary health care there are evident discrepancies in accessibility of municipal capacities for providing services related to reproductive health. Some municipalities have an evidently higher number of gynaecologists and other health workers than in some other municipalities, who partake in health care provision. Discrepancies in geographic distribution are not related to the level of economic development of municipalities.
3. Prevention and protection of pregnant women is not organized in accordance with standards and procedures for pregnancy monitoring.
4. Prevention in the area of reproductive health is at a very low level. There is a particularly evident lagging behind in terms of measures for the prevention of cervix cancer and lack of using standard diagnostic methods.
5. Surveys show that prevention of cervix cancer and breast cancer does not get enough attention, since almost 88% of respondents have never done a mammography test and 81.5 of respondents have never done a Pap test.

6. 42.6% of respondents do not use services of women clinics and specialized outpatient clinics in hospitals.
7. Abortion rate is not known because of lack of data submission from the private sector, which indicates the need of systematic training related to abortion consequences on reproductive health, on younger population in particular.
8. Protection of sexual and reproductive health of adolescents is not organized through modern access to information on these issues and in a manner adequate for youth.
9. Indicators for monitoring reproductive health are not adequate for high-quality health monitoring.
10. Staff training is not compatible with contemporary modes and approach to this issue, which takes into account new lifestyle and work.
11. There are not enough research activities and unique indicators necessary for high-quality evaluation and monitoring.
12. There is no unique database for monitoring both patients and their partners and there are insufficient activities involving vulnerable categories (children, adolescents).

4. REPRODUCTIVE HEALTH IN EUROPE

1. Short overview:

Extremely notable characteristic of the health scene in Europe is a contrast in health and status of health care between western market economies and eastern transition economies. This gap is also evident in the area of reproductive health. Discrepancies are primarily a reflection of economic problems in Central and Eastern Europe followed by political changes which resulted in negative economic growth in most of these countries. Health sector as a whole shows very conspicuous differences, particularly if we compare data on life expectancy: in Western European countries this is about 80 years and in Russia the figure is about 60 years. Average mortality rates differ greatly, as well as infant mortality rates. Reproductive health indicators point out to a relatively high mortality rate of mothers and infants, a high number of sexually transmitted diseases with an upward trend, and a high rate of abortions in comparison to low prevalence of using contraceptive methods. In the framework of this disproportion overburdened by poor health, certain population group are considered to be risk groups:

a. The first group raising highest concerns are adolescents. Increase in sexually transmitted diseases affects this group to the highest extent. A growing number of employees in pornographic industry also belongs to this group and represents a risk group spreading HIV/AIDS epidemic.
b. The second group of population with high risk of reproductive morbidity are migrants. Undesired pregnancy is a common occurrence with the risk of deliberate abortion and its complications. Migrants are also at risk from sexually transmitted diseases and HIV/AIDS, and some are forced to engage in sexual intercourse without protection. The rate of violence against women is high, including sexual abuse (rape).

2. *Programme areas:*

a. *Maternal mortality (NMR)*

Maternal mortality rate in EU is below 10, whereas mortality rate in many independent countries (NIS) is 40 per 100,000 of newborns. Even if abortion is legalized in many European countries, many women are not in the position to use protection services. The aggravating factor is the impossibility of using basic gynaecology care, and the poor quality of service provision which leads to higher maternal mortality rate which could otherwise be avoided. Average maternal mortality

rate in Europe has had a downward trend in the last decade, but discrepancies between countries are still significant.

b. *Perinatal and neonatal mortality*

Perinatal mortality rate in Europe varies from 5-20 per 1,000 of born infants. Neonatal (per 1,000 live birth infants) varies from 6-21 in new independent countries of Eastern Europe, 3-7 in Central Europe (CCEE) and 2-5 in countries of Western Europe.

c. *Deliberate abortions*

Central and Eastern European countries have the greatest rate of deliberate abortions in the world. In Russian Federation, for example, 2.8 million abortions are performed per year. That's the number reported officially, but it is considered to be significantly higher as indicated by WHO research in Armenia. Based on the results of this research deliberate abortions rate is five times higher from the rate officially announced by the Ministry of Health.

Insight into data and results of various research bring us to a general conclusion that the number of abortions per 100 live births in the period from 1980-1998 in Europe is decreasing and has a downward trend.

d. *Contraception*

High abortion rate signifies low of awareness of modern contraceptive methods, limited access to contraception and low quality of services. A large part of the population of Central and Eastern Europe has a very limited access to modern contraceptives. Contraception rate in Europe ranges from 10-70% (10% Albania, 15% Slovakia, 17% Lithuania, 20% Ukraine, 55% Poland, 70.5% Slovenia, 88% Croatia).

e. *Sexual reproductive health of adolescents*

Adolescents become sexually active at a very young age, but proper sexual education and health services are not adequately provided. This is a very important issue in all European countries. Pregnancy rate of adolescents varies from 12-25 (per 1,000 women aged between 15-19) in most European countries. In Great Britain the number is at 47 and in Russian Federation 102.

f. *Sexually transmitted infections (STIs)*

The number of cases of sexually transmitted diseases in most countries of Central and Eastern Europe countries has grown to alarming levels. Particular concern is the increase in the number of syphilis patients, for example 262 per 100,000 inhabitants Russian Federation in 1997, 245 in Kazakhstan, whereas the number in Western European countries is at 0.7. Sexually transmitted infections are a particular problem with adolescent population where the infected rate is higher than in total population.

g. *HIV / AIDS*

Annual reports on new cases infected with HIV virus in Eastern European countries has grown dramatically since 1995. Thus, Russian Federation had 120 cases per 100,000 inhabitants in 1999, and Ukraine had 155 cases.

h. *Uterus cancer*

Human papilloma virus has a crucial role in genesis of cervix cancer. Because of lack of scanning programmes among the population, mortality rate which is connected to uterus cancer in Central and Eastern European countries has grown significantly.

i. *Sterility*

Sterility prevalence in Eastern Europe and new independent countries has been estimated by WHO at 10%b in 1991. The same prevalence figure is also valid for Western European countries. However, recent research posed several questions such as the influence of significant increase in sexually transmitted diseases and post-abortion complications during the 1990s, which have an impact on sterility. The issue of sterility may be seen as a sort of environmental catastrophe. There is not enough data in this area and that is why new research and adoption of standardized approach in treating sterile couples are initiated. To that end, most countries are undertaking steps to evaluate and manage these issues.

j. *Refugees and displaced persons*

Wars in European countries in the last ten years have resulted in a higher number of refugees and displaced persons. This usually refers to women and children. Traditional humanitarian assistance during crises and wars included food supply, provision of shelter and prevention of infective diseases. Maintenance and promotion of reproductive health among these groups was of secondary importance. Therefore, it is necessary to exert additional efforts and focus them on the necessity to maintain and promote reproductive health of these groups.

k. *Migrants*

Between 5-10% of population in Western Europe are migrants. Their needs in the area of reproductive health are often more urgent from the needs of a domicile population. These conclusions are drawn from indicators in monitored countries.

l. *Sexual abuse, violence against women, women trafficking*

These are the problems present in all countries, even and in stable systems of developed countries. Aggravation of social and economic conditions in a major part of Europe has resulted in a higher number of violent sexual relations, prostitution, and women trafficking.

m. *Sexual and reproductive health of the elderly*

Percentage of the elderly in all European countries is growing. Health systems in general, and SRH system as part of it, should respond to their needs. This includes problems related to menopause, andropause, malign diseases the of reproductive system, which appear in older age.

5. STRATEGY FOR REPRODUCTIVE HEALTH

Basic elements of reproductive health strategy for the population in the upcoming period would be focused on the following areas:

1. **Strengthening of health promotion**
2. **Strengthening of the health system and the quality of services**
3. **Partnership building**
4. **Research**

1. Strengthening of health promotion

According to Ottawa Charter principles (1986) health promotion goals refer to increasing the possibility of the population to acquire and maintain habits to promote their reproductive health through information and education. The greatest significance in health promotion is given to education system, family, community, and stakeholders of the health system, particularly those at primary level.

Manners of health promotion:

1.1. *Changing orientation of the health care system*

Health workers, managers of the health care system, those who create rules in health care shall strive to focus the health system towards attaining better reproductive health of the population. Particular attention is devoted to promotion of healthy lifestyles, prevention and health care.

1.2. *Strengthening community action*

Working jointly with non-governmental organizations, the local community will initiate the decision-making process regarding priorities, planning and implementation of the Strategy. Community resources (human resources and financial resources) should particularly promote self-assistance and social support. The local community should be the pillar of activities for health promotion in its territory.

1.3. *Creating supportive surroundings*

Creating a climate where self-support will become common practice with the acknowledgement of cultural heritage.

1.4. *Development of appropriate public policy*

Creating a new approach to the public health system at all levels and sectors is focused at promoting of reproductive health, as one of highly important segments of the overall public health policy.

2. *Strengthening of the health system and the quality of reproductive health services*

Health system promotion and providing quality of services will be enabled through the health care system reform, particularly in the area of primary health care. Chosen gynaecologists, in every municipality, need to provide equal accessibility of this type of health care. Establishment of three regional centres for reproductive health and counselling services for youth in health centres will provide a high level of comprehensiveness of health services and programme quality in the area related to reproductive health promotion.

2.1. *Health care reforms*

Particular attention will be focused on services in youth counselling centres, for pregnant women, family planning, early detection of cancer. Family planning will provide counselling on sexually transmitted diseases. New changes in organization and access to health care in the area of reproductive health require additional training of personnel related to services provision, particularly nurses.

2.2. *Legislation reforms*

Efficiency in providing services related to protection and promotion of reproductive health will depend on legal framework. For the purpose of protecting human rights and providing for ethical principles it is necessary to pose norms, particularly in the area of assisted reproductive technologies and performing abortions.

2.3. *Use and quality of services*

Basic principle for providing high-quality services is obeying ethical principles and right to safety, privacy and reliability, and providing services for vulnerable groups. Obeying these principles, modern organization of capacities in primary health care and training of personnel for working within community-focused approach, will guarantee the quality of services and better health care.

2.4. *Information, training and communication*

Experiences of education on reproductive health introduction in schools, and the use of mass communication technologies, including electronic media, need to be means for spreading and promotion of health in communities. Communication with target groups and their integration in all phases of development and implementation is a key factor of efficiency.

2.5. *Capacity building –education of professionals*

Continuous training of health professionals is a guarantee for the new quality in providing health care. Training programmes for personnel of primary health care are necessary if goals in order to achieve improvements in reproductive health.

2.6. *Gender equality*

Gender equality and joint involvement in issues related to reproductive health would are a key in implementing tasks in this area.

2.7. *Monitoring and evaluation*

Establishment of the national system for monitoring of strategy implementation is a significant prerequisite for determining and monitoring achieved goals in this area. Periodical checkups and screening programmes in reproductive health care would provide an insight into efficiency of implemented approaches, the need for their modifications and the change of policy in this area.

3. Partnership building

3.1. *Public sector – cross-sector cooperation*

There are many proofs which indicate that formal education is a key in providing equal status to women. Education provides a clear approach to young people in the period when they are vulnerable and ready to accept all instructions on sexual and reproductive health. It is necessary to provide a higher degree of integration and partnership in health centres, social welfare centres and school institutions at local community level regarding this area.

3.2. *Private sector*

Non-governmental organizations and private sector are important stakeholders. Therefore, these resources also need to be integrated in the reproductive health strategy.

4. *Research*

The key element for improving health and nursing in this Strategy is knowledge. It is necessary to establish a sound health and scientific system, which will provide:

a. knowledge advancement,
b. knowledge management,
c. research financing,
d. creation of research facilities.

6. IMPLEMENTATION PLAN

for implementing Strategy for Reproductive Health (SRH)

Reproductive choice

SRH area and goals	1. Increase the knowledge of population on reproductive choice and rights	2. Reduce deliberate abortions	3. Improve the use of services for family planning and access to contraceptive methods	4. Provide a wide scope of safe contraceptive options	5. Increase involvement and responsibility among men
Health system reform	Include reproductive choice in national and regional policies of health system reforms	Include family planning in the policy and programmes of primary health care	Integrate family planning, STI, HIV policies and programmes	Develop sustainable policies on accessibility of contraceptive methods for all in need of them	
Legislative reforms	Include contraceptive means in the list of basic medicines	Normative regulation of all contraceptive types (for example: sterilization of man/woman, emergency contraception)	Remove legal barriers for the use of services by minors.	Maintenance or improvement of legal possibility for using the service of safe abortion	Chosen gynaecologists in PHC provide contraception related services
Services quality	Improve utilization by integrating contraception into PHC services	Improve liaising by integrating contraception services, abortion related services and STD/HIV services	Improve quality by giving advice to clients. Improve quality of abortion related services in accordance with factually based principles.	Integrate or strength youth services.	
Information and training campaign	Include or widen reproductive rights and education on contraception in schools, universities, NGOs and other appropriate institutions	Include target groups at all levels of IE&C activities development	Use media in IE&C campaign	Include PHC in education on contraception, particularly in youth counselling centres	Support rights for free and informed reproductive choice
Training experts	Develop/strengthen national and regional centres for raising awareness on family planning. Include regular re-certification of doctors	Integrate family planning in curricula of vocational medical schools, and universities.	Education and training of chosen gynaecologists and nurses on the issue of reproductive choice	Incorporate training and counselling in secondary school curricula. Set standards for the training experts.	

Gender equality	Inform women on their legal right of choice	Focus education on reproductive health in schools and outside schools on both boys and girls	Direct public education on reproductive health and using services by both men and women	Make sure that reproductive health services are accessible and relevant for both men and women	
Monitoring and evaluation	Adopt/implement internationally recognized (WHO) definitions and classifications	Develop valid and reliable national system for monitoring progress in family planning	Improve quality and comprehensiveness of reports on abortions, STI, AIDS.	Introduce periodical monitoring of abortion cases, contraception and related issues	

Safe maternity

SRH area and goals	**1. Reduce mortality and morbidity rate with mothers**	**2. Reduce prenatal and neonatal mortality and morbidity**	**3. Increase knowledge on pregnancy and child birth in population**	**4. Reduce the number of insecure abortions**
Health system reform	Make health of mother and child a priority in funding health care.	Move the focus from nursing aimed at medical treatment to preventive measures	Institutionalize cooperation between different nursing levels	
Legislative reforms	Create a legal framework for responsibilities of different medical professionals and for different levels of obstetrics and perinatal care	Create or improve legal framework for maternity leaves and pregnant women protection from occupational injuries	Legally regulate possible conditions for a third child	
Services quality	Set up, strengthen and monitor standards of good practice. Assure utilization and optimum use of basic equipment and neonatal care	Use technical instructions (WHO) in standardized procedures	Promote antenatal consultations and provide their accessibility	Create a monitoring system for maternal perinatal and neonatal mortality and morbidity. Introduce new, safe techniques of abortions.
Information, training, campaign and representation	Establish a centre for disseminating information on maternal health. Provide specific information for vulnerable groups (adolescents, minorities, migrants).	Integrate safe maternity in health related education in schools	Involve NGOs and IE&C in safe maternity. Develop policy for promotion of mother and child health. Promote and educate on breast feeding.	Promote healthy lifestyles among pregnant women
Training experts	Identify the needs for experts training	Improve training of professionals at all levels, including PHC	Introduce regular re-certification of medial experts	Train services performing abortions to use new and safe abortion techniques, post abortion care and family planning
Gender equality	Acknowledge the attitude of women towards procedures in clinics. Involve partners in prenatal care and childbirth.			Create an environment supportive of breast feeding

Monitoring and evaluation	Develop adequate and reliable national system for monitoring progress in safe motherhood	Adopt/integrate internationally recognized (WHO) definitions and classifications	Monitor anaemia and Rti with pregnant women	Monitor pathologies with pregnant women according to results of national research

STI/HIV/AIDS Control

SRH area and goals	1. Reduce the incidence and prevalence of STI	2. Reduce the incidence of HIV infections	3. Reduce the incidence of uterus cancer	4. Raise awareness of facts connected to STI/HIV
Health system reform	When developing policy award high priority to: 1. awareness of increase and prevention; 2. easy use of services in PHC 3. Integrated prevention from STI/HIV/AIDS	Reduce separation of diagnostics and STD treatment (sexually transmitted diseases) in institutions	Where possible, replace hospitalization of STD patients with outpatient care	Incorporate HIV/STD in all-inclusive RH. Integrate reliable systems for finding partners and reporting services.
Legislative reforms	Remove barriers for integration of STD services in reproductive health			Incorporate the rights of clients (reliability, anonymity, recording partners, etc) into legal measures in cases of STI/HIV/AIDS
Services quality	Use WHO instructions in treatment of STD/HIV/AIDS patients. Improve quality of uterus cancer scanning.	Introduce national manuals for all medical specialists and all types of health care. Prevent transmission from mother to foetus.	Promote antenatal consultations and providing their accessibility.	Include IE&C in health care organization.
IE&C and representation	Raise awareness on risks of STD/HIV among general population with media assistance. Particular attention needs to be focused on high-risk groups.	Stimulate people to assume responsibility in protecting their own health and sexual health of their partners.	Involve the Ministry of Education and Ministry of Health in raising public awareness.	Include target groups in development of IE&C activities. Use public awareness in preventing STI/HIV
Training experts	Implement continuous training to those who provide services on development of new medical achievements in the area of HIV/AIDS.	Provide adequate training for those who provide counselling services and address changes in behaviour.	Provide training through PHC for chosen gynaecologists and hospital specialists, neonatologist, etc.	Provide adequate training for management of STI/HIV cases. Train PHC health workers to recognize uterus cancer.
Gender equality	Focus education on safe sex in and outside schools to both boys and girls. Encourage and enable teenage girls to refuse sexual intercourse without using contraceptives.	Direct public education for prevention of STI/HIV of use of services by both men and women.	Highlight the responsibility of men regarding all preventive activities, promote protection against STI/HIV (use of condoms) for both men and women	Assure for STI/HIV/AIDS services to be relevant and accessible to both men and women. Devote particular attention to women in cases of abuse, who might me infected.

Monitoring and evaluation	Develop adequate and reliable national system for monitoring of progress over control of HIV/AIDS	Adopt/integrate internationally recognized (WHO) definitions and classifications.	Apply systematic monitoring for improvement of scanning programmes for uterus cancer and for management of cases	Initiate research based on behaviour in case of STI/HIV risk. Demand registration of STI/HIV cases from all health care providers (including the private sector).

Sexual abuse and violence

SRH area and goals	**Reduce sexual abuse and violence and its consequences**		
Health system reform	Establish counselling/therapeutic support and safe shelter for victims of sexual abuse and violence	Provide adequate coordination of all activities which are connected to sexual abuse and violence	
Legislative reforms			
Services quality	Train employees in health institutions and developing the sense for recognizing the signals of abuse	Guarantee psychologically and medically / legally adequate treatment of abuse cases	
IE&C and representation	Raise public awareness on sexual abuse and violence	Inform and educate people about the possibilities of avoiding abuse	Inform people on existence of the possibility for getting support in abuse cases
Training experts	Provide special training related to counselling victims of sexual abuse and violence		
Gender equality	Provide an approach which will respect gender of the abuse and violence victim		
Monitoring and evaluation	Set up a database on sexual abuse and violence	Incorporate facts on sexual abuse and violence	Use results of research and monitoring of sexual abuse and violence to raise awareness, prevent and manage cases.

Women trafficking

SRH area and goals	**1. Increase preventive measures against women trafficking**	**2. Protect women from trafficking**
Health system reform	Within centres for reproductive health treat all victims of abuse and sex trafficking	Cooperation of the health sector, social sector, police and NGOs
Legislative reforms		

Services quality	Support NGOs dealing with this problem	Provide optimum safety for victims who wish to witness at court
IE&C and representation	Inform women and community about the risk of becoming a victim of trafficking	
Training experts	Raise awareness of health workers about the problem of trafficking	Adequate protocols for acting in accordance with WHO guidelines
Gender equality		
Monitoring and evaluation		

Breast cancer

SRH area and goals	1. Stimulate scanning and early detection	2. stimulate self-examination with women
Health system reform	Integrate adequate scanning system for breast cancer	
Legislative reforms		
Services quality	Perform mammography regularly for women at high risk	Organize psychological support for patients with cancer diagnosis
IE&C and representation	Inform and educate women on breast cancer. Special programmes and raising awareness of the population.	Initiate or strengthen educational activities for women to learn to self-examine their breasts
Training experts	Training for PHC workers in detection of breast pathology	Training for medical professionals to enable them to provide advice, which is sensitive because of the impact of breast cancer on sexual health
Gender equality	Educate men on how to support their partners in case of breast cancer	
Monitoring and evaluation	Perform systematic monitoring for improvement of scanning programmes and management of cases	

Adolescents

SRH area and goals	1. Inform and educate adolescents on all relevant aspects of sexuality and reproduction	2. Provide easy access to youth services	3. Reduce the level of undesired pregnancies, abortions and STI
Health system reform	Involve actively young people in organizations and implement SRH activities for young people	Integrate SRH activities in overall health and social youth programmes (include sports, cultural activities, etc.)	Create partnership between the government and NGO initiatives by addressing SRH needs for young people
Legislative reforms			

Services quality	Organize YFS within health centres as a support to SRH for youth	Create an atmosphere in these centres which young people will like	Provide counselling that is confidential and sympathetic to the needs of young people
IE&C and representation	Include or improve sexual education in and outside schools by using interactive methods with young people not sexually active yet.	Focus SRH education at knowledge, values and skills development related to behaviour. Provide services where larger groups of young people will be able to meet.	Develop and distribute SRH IE&C materials for different age groups
Training experts	Educate health and school workers in recognizing SRH needs of young people	Initiate education of parents for monitoring sexual development of young people. Represent sexual and reproductive rights for young people	Initiate parent education for monitoring sexual development of young people
Gender equality	Include the sexes issues in IE/&C activities for youth	Focus education with girls in strengthening their self confidence and their readiness to negotiate and in skills of decision bringing	Develop educational activities that will focus on SRH needs and on the responsibility of boys
Monitoring and evaluation	Initiate or improve national monitoring for pregnancy cases among adolescents, abortions and STI	Implement quality research on sexual behaviour and perception of young people (including boys) and the use of results for development and improvement of youth services	

Refugees and displaced persons

SRH area and goals	**Protect the refugees and displaced persons with SRH**
Health system reform	Draft a plan for preparation of all-inclusive SRH services which will enable service provision and integration into PHC
Legislative reforms	Respect the rights of refugees in exercising their right to health care based on instruments of international and humanitarian right
Services quality	Provide SRH services for emergencies in early stadiums of refuge by using ‘package services’. Provide services sensitive towards cultural values of refugees.
IE&C and representation	
Training experts	Train assistant workers among refugees by applying ‘Field instructions for RH in a situation of refuge’, particularly among marginal groups.
Gender equality	Pay particular attention to the possibility of trauma occurring as a consequence of sexual and other type of violence.
Monitoring and evaluation	Apply ’Access in 8 Steps’ in ‘Field instructions for RH in situation of refuge’ for monitoring and supervision

Migrant population

SRH area and goals	**Eliminate differences in SRH status between migrant and resident population**	
Health system reform	Include migrants in SRH planning of promotion programs	Include SRH issues in socially oriented programmes for new migrants
Legislative reforms	Remove legal and administrative barriers for (illegal) migrants so that they can use SRH services	
Services quality	Conduct revision and reduction of cultural barriers for SRH services	Respect other value systems during SRH counselling and during service provision
IE&C and representation	Provide culturally adequate SRH and IE&C materials in the language of migrants	Pay particular attention at IE&C needs of adolescent migrants
Training experts	Train health workers among migrants for SRH counselling and service provision	
Gender equality	Actively address all types of gender discrimination in migrant population, which is a violation of internationally adopted rights on gender equality	
Monitoring and evaluation	Involve 'home country' as variable in monitoring and evaluation system	Initiate research in the SRH area among migrant groups and use results for improvement of IE&C services

The elderly

SRH area and goals	**Improve sexual health of the elderly**	
Health system reform	Implement hormone and other treatments for older people available to groups with lower income	Organize scanning programmes for prostate gland pathology scanning for elderly men
Legislative reforms		
Services quality		
IE&C and representation	Educate and inform men and women on the impact of the aging process on sexual health and on the possibility of prevention	Educate men to recognize the signs of prostate gland pathology
Training experts	Include the implications of sexual health during aging in curriculum of medical schools	Train PHC workers to advice older people in a compassionate way about sexual health
Gender equality	Address the needs of men and women in sexual health programmes	
Monitoring and evaluation	Stimulate research for determining the impact on sexual health of elderly people and effectiveness of preventive interventions	Use the results of research for improvement of sexual health care of older people

The Ministry of Health, health care institutions and non-governmental organizations are primarily responsible for realization of the Strategy implementation plan. Maintenance and promotion of reproductive health requires inter-agency cooperation among governments, establishment of network and determination of mechanisms for necessary coordination.

Acting in cooperation with the Institute for Public Health and the National Commission, The Ministry of Health will develop operational programmes in line with defined priorities. International support for realization and implementation of the strategy needs to be developed through:

- EU cooperation programmes, including PHARE, TACIS, etc.,
- Bilateral programme of East-West cooperation,
- Internationally operational specialized NGOs,
- Network of institutions and organizations, including schools, health care system, universities, research centres,
- Association of professionals working together in the field of SRH,
- European Association of Gynaecologists and Obstetricians,
- European Midwives Association.

7. RESOURCES FOR REPRODUCTIVE HEALTH IMPROVEMENT

The Cairo programme estimated that the USA should allocate USD 18.5 million in 2005 and USD 21.7 million in 2015 for developing countries, and for the countries with transition economies, for the purpose of implementing its reproductive health strategy. It has been estimated that the state itself should provide two thirds of the expenses for action programmes. In many countries the private sectors is an important stakeholder in the provision of resources, as well as NGOs, who mainly provide services which generally could not be used (e.g. family planning associations). Different components of reproductive health and programmes in this area may have different resource grounds and connections with the public sector. Data collection, for instance, could hardly be entrusted with the private practice or the non-governmental sector.

Reproductive health is a priority area of health care measures and, in line with the law, it has the priority in funding from resources of compulsory health insurance and makes a constituent part of the Scope and Standards of Health Services.

A part of programme activities related to mobilization of communities and involvement of other sectors in implementation of the Strategy, may be provided through joint projects and activities within the objectives of other systems, particularly regarding the component of education.

7.1. MONITORING AND EVALUATION

Progress in implementation of the Strategy and goals achievement requires that the strategy be posed on regular grounds with status indicators in a given time and space. The World Health Organization suggested 17 indicators on the global level. The Strategy defines indicators adjusted to terms and national indicators. Evaluation is a periodical systematic analysis of experiences. It provides for the programme to be identified, re-examined and future course suggested. The goal is to determine the scope of achieved results through different programme activities and to set new research goals. There are several methods for programme evaluation. The World Health Organization has started suggesting fast evaluation methods (REM) since 1993, where health service providers from different levels work together in fast and overall evaluation of the situation (this method is applied to family planning programmes, area of mother and children health in several countries). Programme evaluation is a critical component of the strategy plan and it needs to be designed in the programme from the beginning, with the use of global and national indicators.

RATIONALE

Reproductive health is an important segment of health which receives special attention from the World Health Organization and other international organizations through different programmes and activities within health policy of every country.

Improvement of reproductive health policy is a complex process which involves many segments of social infrastructure and not only the health system. Cross-sector approach to the issue of reproductive health is a necessary prerequisite to reforms in this area.

Following modern tendencies and recommendations of the World Health Organization, the Ministry of Health of the Republic of Montenegro initiated several programmes incorporated in a document entitled Strategy for Preservation and Promotion of Reproductive Health. The goal of the Strategy is to focus the activities of the health system and other sectors towards the improvement and protection of reproductive health. There is an organized action in the area of public health and protection of the vulnerable categories, mothers and children in particular. This is a contribution to the actualization of the Millennium Goals and recommendations of the World Health Organization. Starting from recommendations and obligations determined by international documents, the Ministry of Health established the Commission for Reproductive Health as a professional body which has contributed to drafting of the Strategy for Preservation and promotion of Reproductive Health in the Republic of Montenegro.

Guided by recommendations of the World Health Organization, the Strategy provides medical treatment and health care in the primary health care, provides community treatment, creates and involves the community, family, users, develops national policy and legislation, develops qualified personnel, provides education and re-education, integrates the health sector with other sectors, performs monitoring of the current situation in reproductive health in the community and supports research.

The Strategy develops goals and defines steps for realization of planed goals for improvement and protection of reproductive health. Particular attention is dedicated to raising awareness of the population regarding reproductive health. The existing low level of health care in the area of reproductive health, determined on the grounds of conducted polls, and on the grounds of collected data on available indicators, indicated the existence of problems, which should be overcome through organized action of all relevant subjects in the community. The existing system of reproductive health care has its advantages and disadvantages, since it is mainly based only on health service, without participation of other sectors which can significantly act in prevention of diseases. Application of principles from this Strategy should eliminate the stated problems. Reform and strengthening of reproductive health will follow the reform of the overall health care system, initiated with primary health care reform. PHC gains importance with this Strategy through organization of the new model of chosen gynaecologists, youth counselling centres and reproductive health centres. System of changes is synchronized in order to provide better health of the population in all its segments and to increase the accessibility and quality of services, which imposes the necessity of cross-sector cooperation in the field of reproductive health.