National Strategy for Sexual and Reproductive Health

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MINISTRY OF HEALTH, SOCIAL SERVICES AND EQUALITY

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National Strategy for Sexual and Reproductive Health

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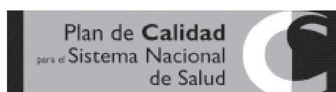

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Technical Note. Description of the document

This document is structured into 4 sections:

Introduction

Briefly outlines the Sexual and Reproductive Health Strategy from a gender point of view with an overall and independent consideration of sexual and reproductive health.

Sexual Health

Reports the work methodology to develop the strategic lines. Each of the 4 specific sexual health lines includes aims and recommendations to develop this:

Strategic line 1: Health promotion
Strategic line 2: Health care
Strategic line 3: Training professionals
Strategic line 4: Research, innovation and good practices

Reproductive Health

Reports the reproductive health situation in Spain providing data from the National Health Survey (ENS), Vital Statistics from the Spanish National Statistics Office (INE), from the World Health Organization (WHO) and studies performed on the topic. The document continues with the specific strategic lines for pregnancy, the delivery, neonatal period and puerperium in addition to transversal lines corresponding to the main aspects which should be integrally observed during the entire reproductive process:

Strategic line 1: Promotion of health in pregnancy
Strategic line 2: Health care during pregnancy
Strategic line 3: Care during the delivery. Refers to the Strategy for Care during a Normal Delivery in the NHS, which has its own strategic lines, with specific aims and recommendations, currently under development.

Strategic line 4: Care from birth up until the first week of life
Strategic line 5: Promotion of maternal breastfeeding
Strategic line 6: Care of the hospitalised newborn
Strategic line 7: Care during the puerperium
Strategic line 8: Health care during the puerperium
Strategic line 9: Training professionals
Strategic line 10: Participation of women and partners
Strategic line 11: Institutional coordination
Strategic line 12: Research, innovation and good practices

Follow up and assessment of the Strategy for Sexual and Reproductive Health

This covers the theoretical framework from setting up the assessment and the methodology to follow in order to develop this.

Finally, the document ends with the bibliography consulted both on sexual and reproductive health and a list of acronyms of the terminology used.

1. Introduction

Sexual and reproductive rights have been recognised by the international community as human rights in declarations, conventions and pacts by the United Nations and other internationally approved documents.

To ensure the development of healthy sexuality in human beings and societies, sexual rights have to be recognised, promoted, respected and defended by all societies with all means available. In this way sexual health will be the result of a context which recognises respects and exercises sexual rights.

The concept of sexual rights is constantly evolving and being reviewed. Its conceptualisation is the result of a process which arose from the claims of social movements such as the international women's movement or international organisations such as Amnesty International, Human Rights Watch or LGTB (Lesbians, gays, transsexuals and bisexuals) groups. In the same way, different organisations such as the International Federation for Family Planning (IPPF) and The World Association for Sexology (WAS), has recognised and made explicit declarations on sexual rights.

For their part, reproductive rights deal not only with the right to make a decision about reproduction, but also the undertaking to guarantee suitable prenatal and postnatal health care. In addition, as covered in the Convention on the Rights of the Child, adopted by the United Nations General Assembly on 20 November 1989, countries should take the necessary measures to ensure that all sectors of society are aware of the basic health and nutrition principles during pregnancy and breastfeeding.

One of the basic rights of women on reproductive health is the right to information and to decide freely. This implies offering women alternatives based on scientific evidence so that they can take informed and autonomous decisions on the care they wish to receive during pregnancy, childbirth and the puerperium and on the care they should provide to the infant.

It is advisable for women during the puerperium and breastfeeding to be familiar with their work-related rights and provide them both with the possibility of combining their personal, family and working life with raising children and joint responsibility of the partner as the option to maintain breastfeeding by means of maternity leave and ensure they have work-related and social coverage during this time.

The right to protect the newborn is fundamental; the newborn needs to be provided with quality care based on immediate and uninterrupted skin to skin contact following birth, accompaniment by the partner or whoever the women decides and development of maternal breastfeeding as the best option to provide them with physical and emotional well being.

International framework

The "Convention on the Elimination of all Forms of Discrimination against Women" (English acronym CEDAW) is the first international treaty which expressly recognises human rights of women. It was adopted by the United Nations General Assembly in 1979 and ratified by Spain.

The human rights of women and girls are an unalienable, integral and indivisible part of universal human rights. Full participation under equal conditions of women in political, civil, economic, social and cultural life on a national, regional and international level in addition to the elimination of all forms of discrimination based on sex are priority aims of the international community. For the first time sexual rights of women are included as human rights.

Therefore, the human rights of women should form an integral part of the human rights activities of the United Nations (Vienna Declaration and Action Programme, 1993)

This conference encourages countries, intergovernmental and non-governmental institutions and organizations to:

- Eliminate violence against women in public and private life and all forms of sexual harassment and exploitation including trafficking in women, systematic cases of rape, sexual slavery and enforced pregnancies.
- The protection and promotion of human rights of women and girls.
- The need for suitable care of maternity to eradicate any kind of action which goes against the dignity and worth of people.
- The right of women to have access to suitable health care and the broadest range of family planning services with the purposes of contributing to equality between men and women.

In addition, from the Fourth World Conference on Women by means of the Platform for Action, the human rights of women include their right to exercise control and freely and responsibly make a decision on matters related to

their sexuality including sexual and reproductive health, free of coercion, discrimination and violence.

On a European level it is worth noting that the European Parliament approved Resolution 2001/2128(INI) on sexual and reproductive health and rights, making a set of recommendations to governments of member states on contraception, unwanted pregnancies and sexual education. It also covers the inequality and difficulties suffered by European women over access to sexual and reproductive health services, voluntary abortion based on their income, or country of residence.

Therefore, the theoretical approach considered for drawing up this strategy has taken into account the most relevant aspects provided from the following events:

- International Conference on Population and Development, El Cairo, 1994
- Fourth World Conference on Women, Beijing, 1995
- Millennium Summit, 2000
- Action lines in the European Union
- The bio-psychosocial approach to health recommended by the WHO

National context

In prevailing Spanish legislation, there are some references to sexual health, equality of opportunities and violence against women, including sexual harassment and violence.

Considerations included in the following were taken into account:

- **Organic Law** 2/2010, of 3 March, **on sexual and reproductive health and voluntary abortion.**
- **General Health Law** 14/1986, of 25 April.
- **Basic Law 41/2002,** of 14 November**, regulating the patient's autonomy and rights and obligations on clinical information and documentation.**
- **Law 16/2003,** of 28 May**, on Cohesion and Quality of the National Health System**, which determines public health coordination and cooperation activities during exercise of their respective competencies. The fundamental component of linking of the Spanish NHS is the Interterritorial Board of the NHS (CISNS) with the Senior Inspectorate

which will ensure compliance with the agreements taken within this Board.

- **Law 44/2003**, of 21 November, **on regulation of the health professions.** This regulates fundamental aspects of graduate health professionals regarding their practice, general structure of professionals' training, their professional development and participation in the regulation and planning of the health professions themselves. European Council Directives must be complied with as to aim to achieve but member states are able to select the form and means to achieve these aims. Therefore, Directive 80/155/EEC of 21 January 1980 relating to the competencies of specialists in obstetrics and gynaecology nursing was incorporated into Spanish legislation by Royal Decree of 28 June 1991, establishing the obstetrics and gynaecology care activities in relation to reproductive health and specifically, the monitoring and evaluation of normal pregnancy and care during childbirth.
- Royal Decree 1030/2006, of 15 September, which establishes the **portfolio of common services of the National Health System** and the procedure for their update. In Annex 2 on primary care, point 6.2 of adolescence care services, refers to the *promotion of healthy conducts in relation to sexuality, avoiding unwanted pregnancies and sexually transmitted infections.* Similarly, in point 6.4 there is a specific section on care of people living with HIV and sexually transmitted infections with the aim of contributing to the clinical follow up and improvement of their quality of life and avoiding risky practices.
- **Organic Law 3/2007,** of 22 March**, for effective equality of men and women**, which, by means of article 27, covers the undertaking to integrate the principle of equality of opportunities into health policies.
- **Strategic Plan for Equality of Opportunities (2008-2011)**, those actions related to sexual and reproductive health.
- **Multisectoral plan against HIV infection and AIDS. Spain. 2008-2012, from the MSPS**.
- **Action plan for Disabled Women** approved by the Council of Ministers on 1 December 2006.
- **Organic Law 1/2004,** of 28 December**, on Measures for Integral Protection against Domestic Violence**, which recognises that domestic violence includes aspects related to sexual aggressions and sexual harassment and consequently equality, respect and autonomy in affective and sexual relations. Therefore, art. 1 includes in the definition aggressions which prevent sexual freedom.

- **Organic Law 10/1995,** of 23 November**, of the Criminal Code** which covers those crimes against sexual freedom and indemnity, specifically sexual aggressions (art. 178 – art. 180), sexual abuses and sexual harassment.

Differential handling of sexual and reproductive health

Numerous studies in relation to sexual and reproductive rights consider these as one inseparable whole. It is assumed that if they encourage and guarantee reproductive rights, sexual rights will also be included. In this way, it has resulted that the majority of policies, programmes and actions undertaken tackle some aspects of sexual rights within the scope of reproductive rights or they put sexual rights to one side.

Therefore, it is necessary to set up strategies for action, programmes and projects aimed directly at improving sexual health and therefore, their aims have a direct relationship with achieving this.

General aim of the National Strategy for Sexual and Reproductive Health

The general aim of this Strategy is to offer quality care to sexual and reproductive health within the National Health System.

2. Sexual Health

2.1. Work methodology

To prepare the sexual health section of the National Strategy for Sexual and Reproductive Health (ENSSR), we have taken the following steps:

1 **Preparation of the theoretical framework for Sexual Health with a gender approach**. In the main we have tried to reflect on the evolution of the treatment of sexual health from a gender perspective and its consideration nationally and internationally. Therefore, we have considered the different implications of sex for how men and women experience their sexuality in addition to the different stages of life, from childhood up until maturity. The method followed was the analysis of secondary sources and existing bibliographical review on sexual health or as sexual and reproductive health as most investigations deal with this jointly. In addition, official publications from national and international organisations, specialised publications and digitalised documents, have been reviewed.

2 **Creation of an ad hoc group of experts for the National Sexual Survey (ENSS).** According to expert criteria on sexuality from scientific societies from the scope of the intervention, academic setting and social and women's movement and gender approach, this group was formed with the aim of orienting content, sections and thematic blocks of the ENSS. The group of experts was called to an initial workshop on 12 December 2007, to manage the content of the survey. The Women's Health Observatory drew up a document based on the gender approach in all thematic blocks, and reformulated some issues in the meeting of 30 April 2008 and the Sociological Research Centre (CIS) prepared the definitive questionnaire for the ENSS.

3 **Constitution of Institutional and Technical Committees.** The Institutional Committee (IC) is comprised of people designated from Autonomous Communities and the Technical Committee (TC) by scientific societies, social organisations and experts on sexual health.

The functions of the **Institutional Committee** were:

- Collaborate providing the available information in the situation analysis.
- Identify the requirements for priority actions on sexual health.

- Assess the relevance and viability of the aims and recommendations proposed.
- Validate the content of the sexual health proposal for its presentation to the Interterritorial Health Council.

For its part, the **Technical Committee** has had the duty of collaborating and advising, by means of relevant technical scientific information, on the aims and recommendations.

These two committees have worked jointly and interactively, both by means of attending meetings, and by means of the virtual work platform in an e-Room network, part of the MSPS, and by means of e-mails.

Working meetings held and requiring attendance were the following:

- Creation of the Institutional Committee on 17 June 2008.
- Creation of the Technical Committee on 10 July 2008.
- "Integral Care of Sexual Health in the NHS with a gender approach" days, held in Mahón on 25 and 26 September 2008. Both Committees participated to review the situation analysis report and work on the aims and lines of action.
- Meeting of 28 October 2009 with both Committees to review the final aims and recommendations of the Sexual Health section.
- Meeting of 26 April 2010 with both Committees to agree on the draft document of the Sexual Health section of the ENSSR.

4 **Diagnosis of the Sexual Health situation in Spain**. With the aim of being able to identify and ascertain those key matters as regards organisation, resources, services, plans, protocols and programmes related to sexual health care and methods for preventing sexually transmitted infections (STIs) and unwanted pregnancies in Autonomous Communities and Cities with autonomous status, three questionnaires have been prepared from the MSPS to collect the information. From the data collected by the Institutional and Technical Committees, a descriptive analysis of sexual health care in the NHS has been performed, and the keys for the strategic lines have been obtained.

5 **Search for scientific information.** It was based on existing information sources on Internet, looked in databases, websites of national and international public health institutions, portals, etc. The sources of information consulted were:

- Databases specialised in health sciences: Pubmed, IME, Scielo, Excelencia Clínica, Cochrane, Biblioteca Virtual en Salud (BVS) and ISI Web of Knowledge
- Databases specialised in gender: Genderbias, Gender Inn and Siyanda
- Databases specialised in social sciences: Compludoc, ISOC- Political Sciences and Sociology
- Web portals and search engines: Google, Scirus, Fisterra, ISIS Internacional
- Health journals: Entre Nous, Mujeres y salud, Gaceta Sanitaria
- Official institutions: Ministry of Health and Social Policy, Women's Health Observatory, WHO, Pan American Health Organization (PAHO), Public Health Observatory of Cantabria, Andalusian School of Public Health, European Union-Health
- Scientific and Professional Societies: SESPAS
- Universities: University of Alicante, University of Cantabria, Linkoping University
- Libraries: Emakunde – Basque Institute of Women

The search methodology has been oriented based on the four strategic lines of the sexual health section.

The search criteria have been established based on databases or resources used, alternating descriptors and free language in English and Spanish. Regarding the terms used they have been selected and adapted to the resource used. "Sexual health" and "sexuality and sex" are related to the strategic lines and other terms such as joint responsibility, promotion, contraceptive methods, awareness, violence, communication, education, empowerment, men, health care, social services, assessment, training, innovation, etc. Once the documents were recovered, we selected those which tackled broader content than those relating to reproductive health and STI.

Once the search was over, we grouped together the documents selected into subject blocks to assess their relevance. The majority of the articles recovered belonged to the scope of social and anthropological sciences. We barely found relevant information in the area of health sciences. We also found a large number of documents in published journals although not all these have been included; these journals reveal the growing interest of society in matters of concern to us, tackled from a different point of view than that up to now.

We drew the conclusion that the sexual health bibliography is sparse and fundamentally related to reproductive health: the pregnant woman, prevention

of pregnancies, youth education, STI-HIV which leaves a gap for sexual health information seen integrally and holistically as set out by the strategy.

2.2 Situation of sexual health care in the NHS

Currently, the social situation in Spain regarding conceptions about sexuality has undergone considerable changes, especially in the last 25 years. However, this social change has not been accompanied by a public policy aimed at sexual health from an integral conception. Therefore, with the purpose of filling this gap, this sexual health section aims to drive forward action lines and promotion, care and training on sexual health which can be implemented within the NHS.

To perform this task and set out future plans of action it is necessary to have an initial diagnosis of the situation presented by Autonomous Communities and Autonomous State Cities. Therefore, the MSPS set up the two Technical and Institutional Committees in July 2008 in which all the Autonomous Communities and Autonomous State Cities are represented with the purpose of working on the design of sexual health action lines.

As an initial tool for collection of information, we prepared an exploratory online questionnaire whose results have served to obtain an initial picture of sexual health care in different Autonomous Communities and Autonomous State Cities. Subsequently, in May 2009 collaboration was requested to collect information on contraception. Most communities facilitated information in this regard.

In light of the results we noted territorial variability on sexual health care. There are various Communities which do not consider this a priority area of intervention in their respective health plans and some regulate this care in specific regulation focused on aspects related to prevention of STI-HIV and unwanted pregnancies. The majority have specific programmes and protocols for contraception in their portfolio of services.

According to the information declared by Autonomous Communities and Autonomous State Cities, to a lesser or greater extent they develop plans, programmes, protocols or guides relating to sexual health where they perform actions related in the majority of cases to sexual affective training and education for young people, emergency contraception, telephone information on activities related to the prevention of HIV.

In some Autonomous Communities and Autonomous State Cities specific services are organised for the **young population**. This deals with services of very different nominations, characteristics, provisions, time schedule and

accessibility. These include: *Consulta Joven* (Young people's consultation) in the context of certain health centres and secondary schools, *Tarde Joven* (Young people's afternoon) in some health departments, advice on youth sexuality, youth centres for contraception and sexuality, young people's hotlines for sexual information and specific websites, among others. The way in which Autonomous Communities and Autonomous State Cities implement their programmes of action is diverse.

The majority of Autonomies develop STI-HIV prevention programmes considering different population groups such as for example men who have sex with men (MSM)[1], sex workers and the immigrant population by means of information and promotion of male condoms (to a lesser extent the female condom) by means of, for example, slot machines. Few Communities focus their attention on information campaigns on new hormonal and/or emergency contraception methods.

Some Autonomous Communities offer sexological care or training from the perspective of promotion of health aimed towards a preventive and care viewpoint. In addition, as argued in the theoretical framework, sexual health is still, in practice, related to reproductive health.

It should be noted the relationship existing within Autonomous Communities and Autonomous State Cities with other institutions outside the scope of the health sector for sexual health care. Entities which have **inter-institutional coordination to develop these actions are mainly departments or regional departments of education, equality/women, well-being and youth, local town councils or NGO**s.

Similarly, we should not overlook the notable role played by **NGOs** in virtually all Autonomous Communities as it is these institutions which often carry out activities. Conversely, as seen in the information provided by the Autonomous Communities and Autonomous State Cities, there is barely any coordination at all with the Regional Departments of Labour and unions in relations to sexual health care, if we consider the relationships between work conditions and quality of life.

Considering the responses of Autonomous Communities and Autonomous State Cities to the questions from the questionnaire referring to the **inclusion of a gender approach** in their programmes, Autonomous Communities state that they incorporate it although most do not explain how to apply it in the initiatives to which they refer.

[1] In general, when considering that sexual practices between women do not entail risk of infection STI-HIV, they are barely included as target groups for preventive campaigns although there is little research in this regard.

On the other hand, some questions from the questionnaire go into the **breakdown by sex** of certain actions and we observed differences depending on what these are. For example, the prevention of STI and HIV, together with prevention of unwanted pregnancies, are the most common actions of both sexes followed by the capability to take decisions and personal autonomy. However, actions which appear in the questionnaire where less work is done are social support, handling stress and partner relationship in equality. There are also more actions aimed at women than men when this has to do with matters such as satisfactory sexuality, body image and personal autonomy.

In relation to the availability of data on **the most prevalent sexual health problems,** there is information on STI, HIV/AIDS and voluntary abortions in the majority of Autonomous Communities as these are the initiatives being carried out. In addition, some have information on requests for sexological consultations. Only a few incorporate data from health surveys, sexual habits or databases of programmes or actions. To a lesser extent it is also tackled emergency contraception in addition to sexual awareness and education.

The **data collection system** on sexual health by means of electronic clinical histories in primary care is an aspect pending development in Autonomous Communities although they stress the efforts made to incorporate questions related to violent situations and other life events.

As for **training on sexual health**, virtually all Autonomies consulted state that they offer training programmes on sexual health care aimed at health professionals. The primary care services are those which offer most training followed by specialised care and three Communities state they have programmes aimed at emergency health care professionals. Two of these Autonomous Communities impart training to administrative personnel in addition to outside health services.

There is little financing for **research and innovation** in sexual health by the majority of Autonomous Communities and Autonomous State Cities although some have started to drive forward studies and others according to data provided in the questionnaires have not financed or commenced investigations into sexual health. Moreover, five Autonomous Communities state they are aware of best practices in sexual health care.

Finally, regarding the **assessment of programmes**, there is no data on explaining how they perform whilst this aspect is fairly well considered in the schedules for plans referred by Autonomous Communities although rarely carried out. Regarding the assessment of **satisfaction results** both by users and professionals who work in care services for sexual health; this is an aspect pending development in spite of the fact that action plans incorporate this assessment.

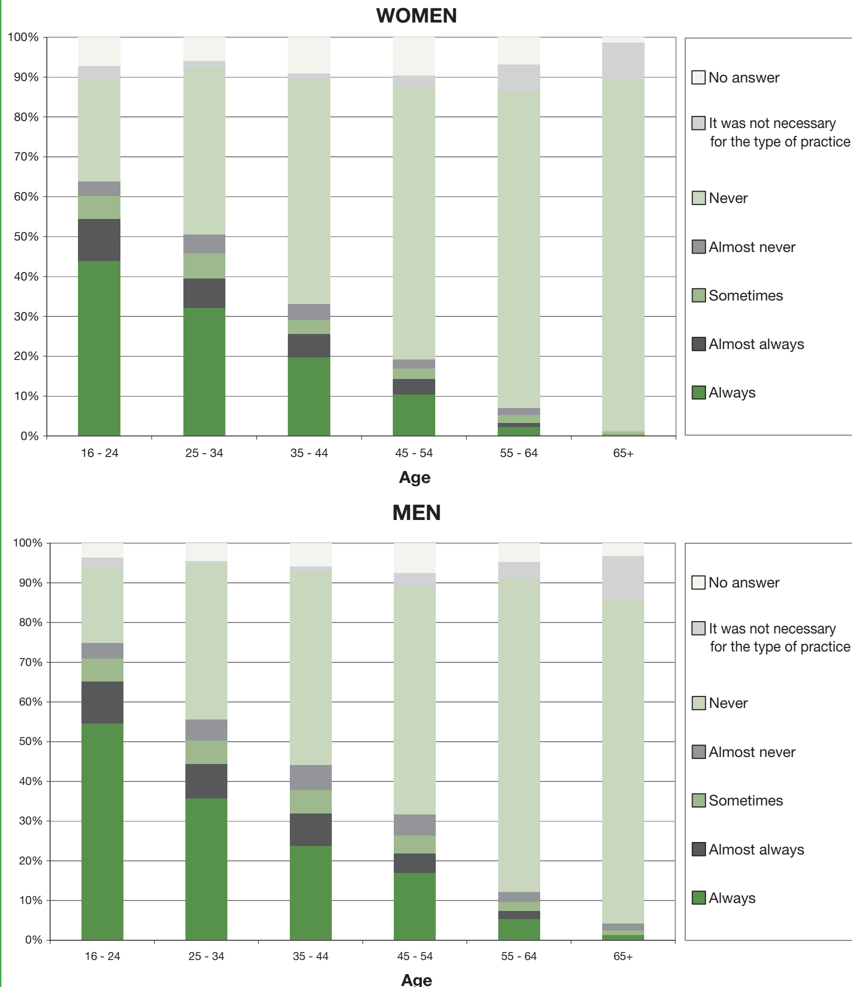
2.3. An approach to the situation of the prevention of STI and contraception in Spain

According to data from the National Sexual Health Survey, 2009 (MSPS-CIS no 2780), the characteristics of sexual practices and kinds of methods used to prevent STI-HIV and unwanted pregnancies vary based on the kind of bond established with the sexual partner. Although the majority of people surveyed report having a stable partner (77.2% of men and 74.1% of women), significant differences can be differentiated between these and occasional partners which we will see below.

a) Use of methods to prevent STI and pregnancies in **stable partners**

- The use of **methods to prevent STI with the stable partner** is not very frequent according to data collected in the Survey. Women refer less use in all age ranges, and between 16 and 44 only 42.2% compared to 49.2% of men use them; this decreases in the age range 45 to 54 with 21.8% in men and 14.0% in women. The most frequently used method for both sexes is the male condom and the response is upheld for all age ranges (91% of men and 89.3% in women) although the youngest groups refer it more.

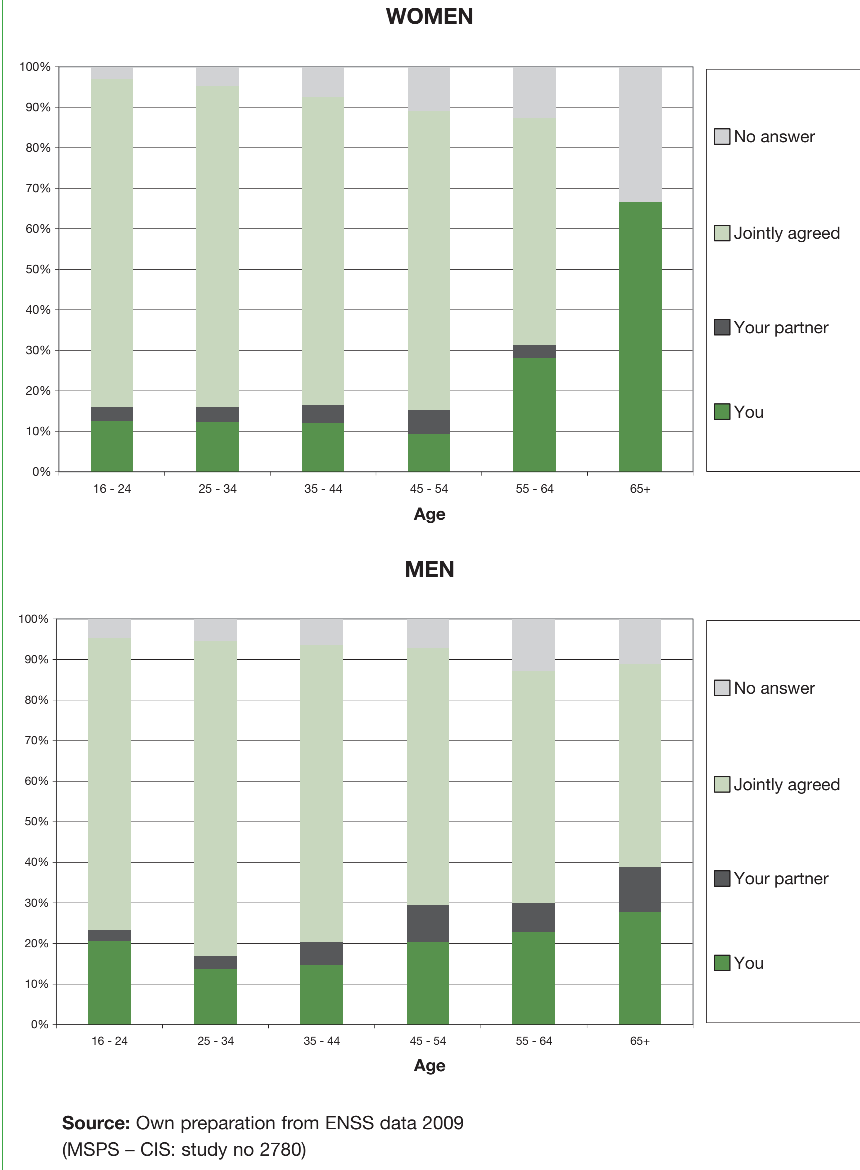
Graph 1. Frequency in the last 12 months of use of methods to prevent STI-HIV/AIDS and hepatitis (stable partner)



Source: Own preparation from ENSS data 2009 (MSPS – CIS: study no 2780)

Its use is agreed jointly by men (72%) and women (77.5%), although patterns reverse in relation to methods to prevent pregnancies as men state they decide this themselves to a larger extent than women (17% compared to 12.5%)

Graph 2. **Person who decides to use methods to prevent STI**



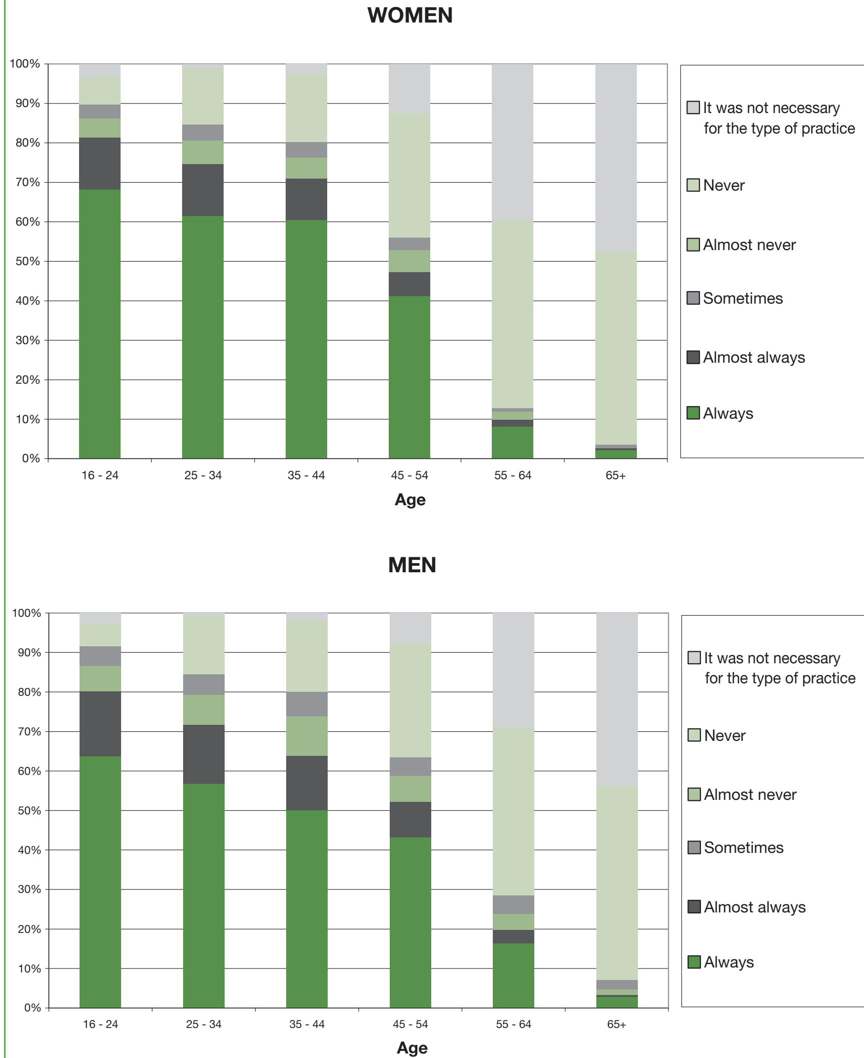
Source: Own preparation from ENSS data 2009 (MSPS – CIS: study no 2780)

- Much more frequent is the **use of methods to prevent unwanted pregnancies with the stable partner,** although this reduces throughout life without significant differences by sex being revealed. Women state

they use this always and almost always somewhat more than men age 16 to 44 (74% of women and 69.8% of men); this reverses in the age range 45-54 when use decreases considerably to 46.8% in women and 51.6% in men. The contraceptive methods most frequently used by stable partners are the condom for men (80.8% of men age 16 to 24 and 51.7% of men age 25 to 54) followed by the contraceptive pill (23.2%). For women the order is similar although percentages decrease; young people age 16 to 24 use the male condom in 68.5% of cases and the remainder, age 25 to 54 in 43.7%. Regarding the use of the contraceptive pill in women, 33.4% for those age 16 to 34 use it and it decrease to 18.1% in the age range 35 to 54.

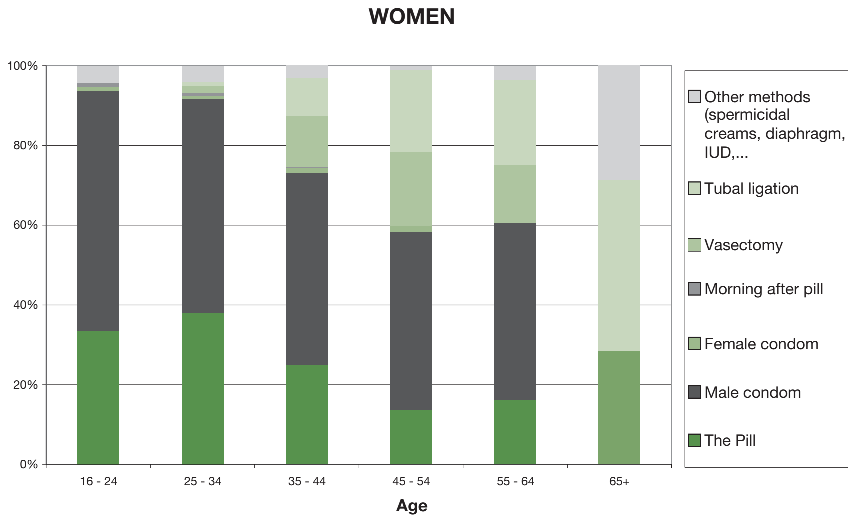
Its use is mainly the result of a decision negotiated by the couple especially between younger men and women: this is indicated by men (67.9%) and women (65.8%). However, figures reflect that responsibility over prevention fall predominantly in women as 24.4% state that they decide this on their own compared to 13.4% of men.

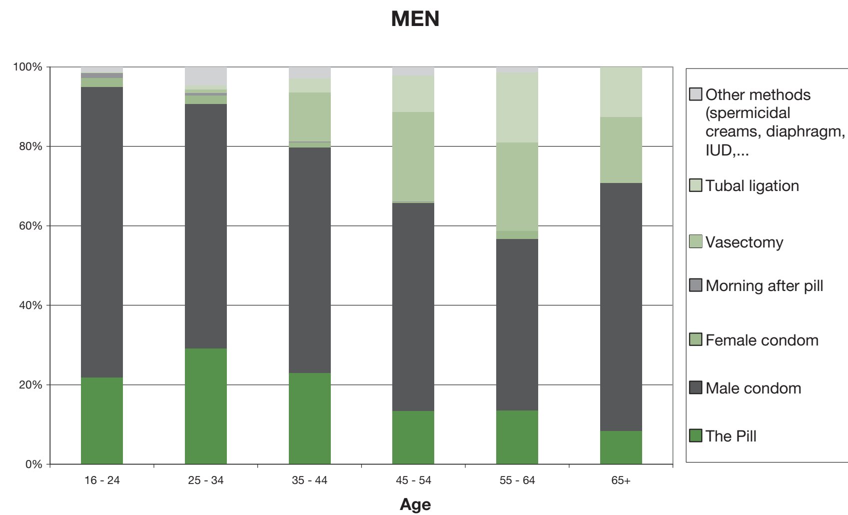
Graph 3. **Frequency in the last 12 months of use of contraceptive methods, (stable partner)**



Source: Own preparation from the ENSS 2009 (MSPS – CIS: study no 2780)

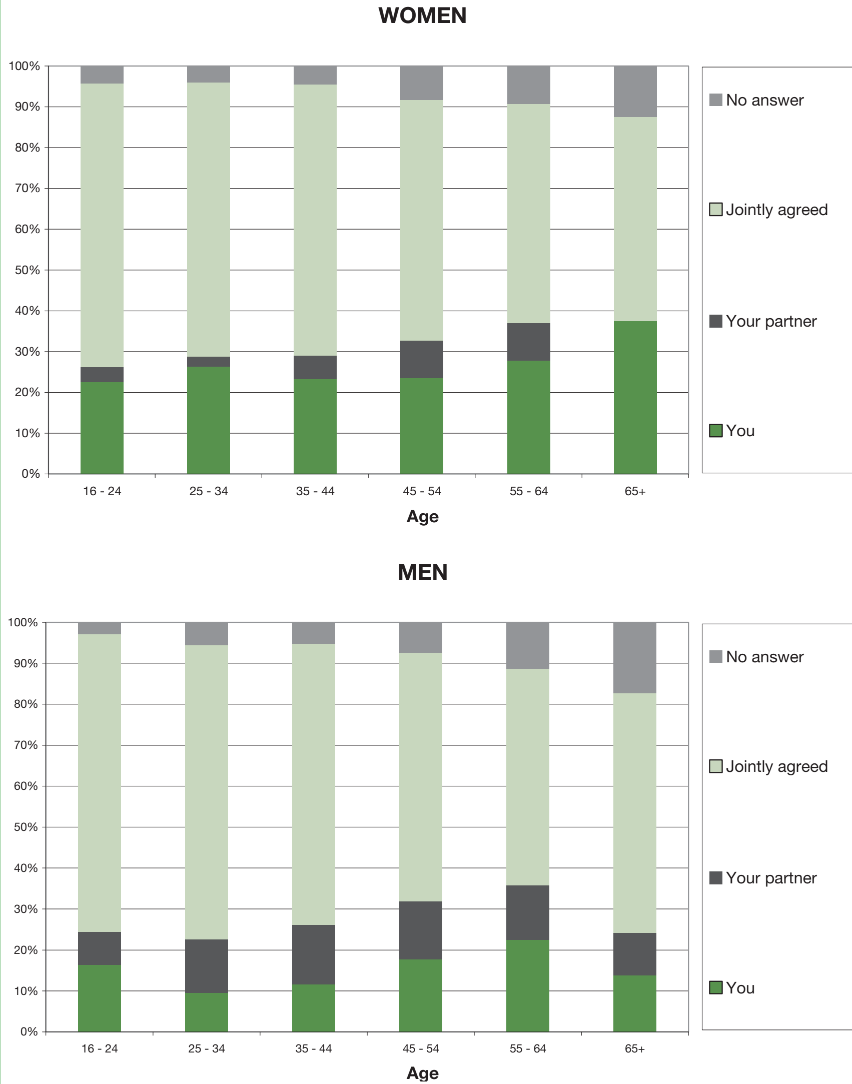
Graph 4. Methods used





Source: Own preparation from the ENSS 2009 (MSPS – CIS: study no 2780)

Graph 5. Person who decides to use these methods



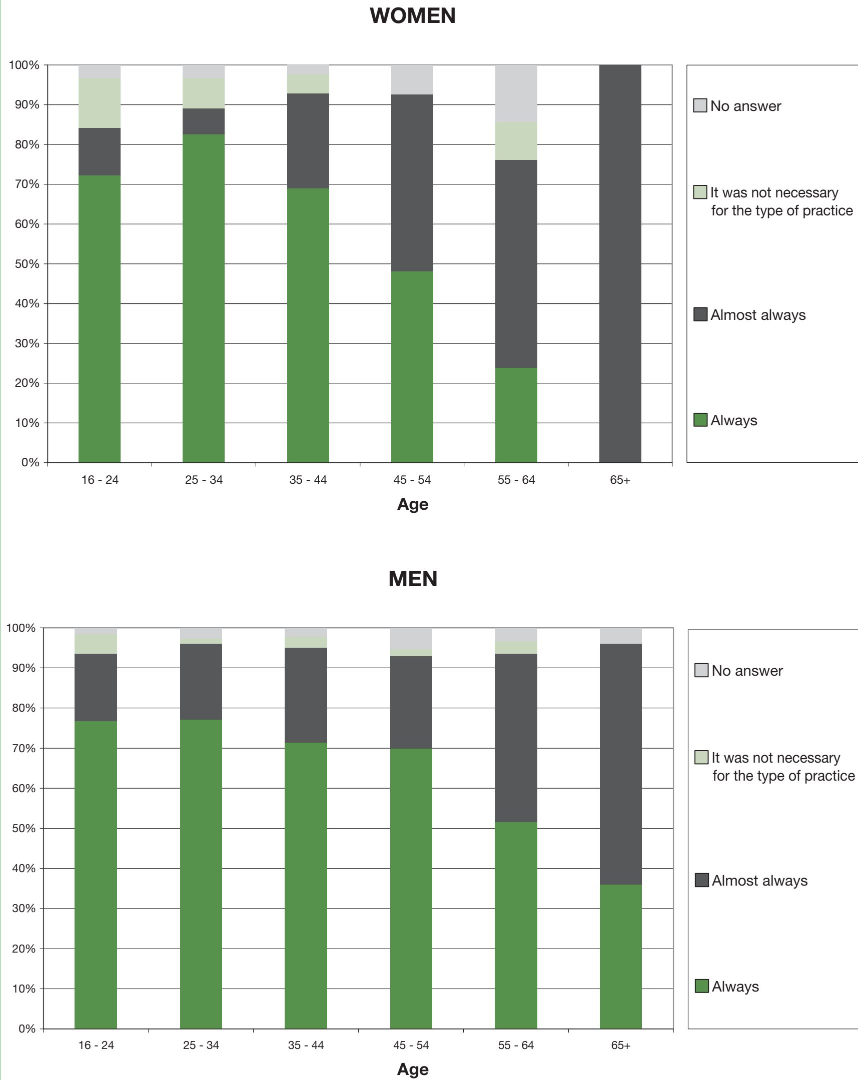
Source: Own preparation from the ENSS 2009 (MSPS – CIS: study no 2780)

b) Use of methods to prevent STI and pregnancies in **occasional partners**

- The data relating to **use of methods to prevent STI** are quite notable: 22.1% of men and 18.6% of women state they have not used any method, while this figure is lower in young people of both sexes. Of those who used a method, the most frequently used is the male condom (97% of men and 96% of women), while use of the female condom is very rare: 1.3% of men and 2.8% of women state having used this.

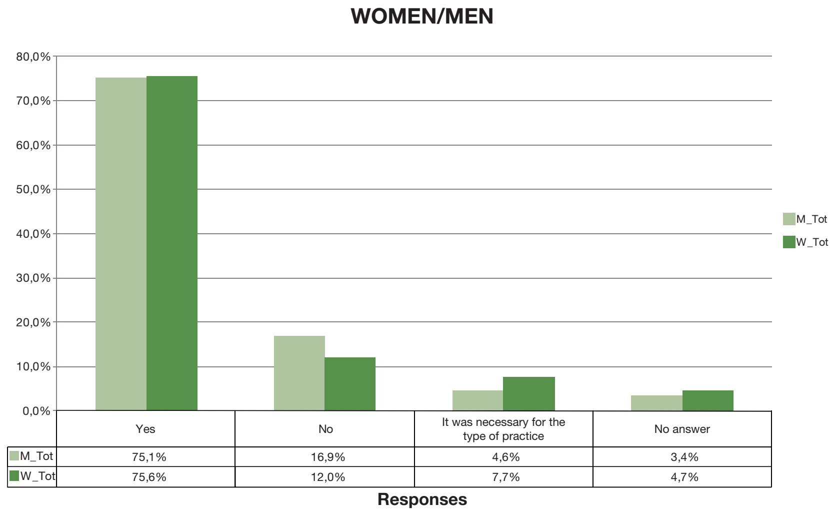
In relation to **methods to prevent pregnancies**, use increases up to 75.3% with no significant differences by sex, especially in younger age groups. We should not fail to highlight however, that 17.0% of men and 12% of women point out they have not used any method at all. The male condom is the most frequently used method by men (92.1%) and women (85.2%) followed by the contraceptive pill (7.2% of men prefer this method compared to 23.0% of women).

Graph 6. Use of methods to prevent STI, HIV/AIDS or hepatitis, sporadic or occasional partner.



Source: Own preparation from the ENSS 2009 (MSPS – CIS: study no 2780)

Graph 7. **Use of contraceptive methods, occasional or sporadic partner.**

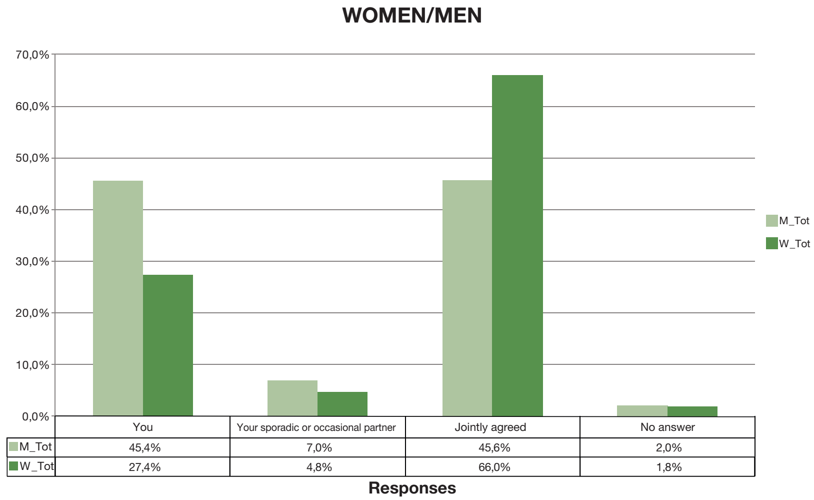


	Yes	No	It was necessary for the type of practice	No answer
M_Tot	75,1%	16,9%	4,6%	3,4%
W_Tot	75,6%	12,0%	7,7%	4,7%

Source: Own preparation from the ENSS 2009 (MSPS – CIS: study no 2780)

- The patterns for making the decision are similar to the use of methods to prevent STI and prevention of pregnancies. Differences were observed in both cases. The percentage of those who state they decide this individually increases considerably with quite notable differences by sex, as while men are distributed more among those "who agree this jointly" (45.6%) and decide it themselves (45.4%), women state they agree this jointly to a larger extent than men (66.0%) and only 27.4% state they decide this themselves.

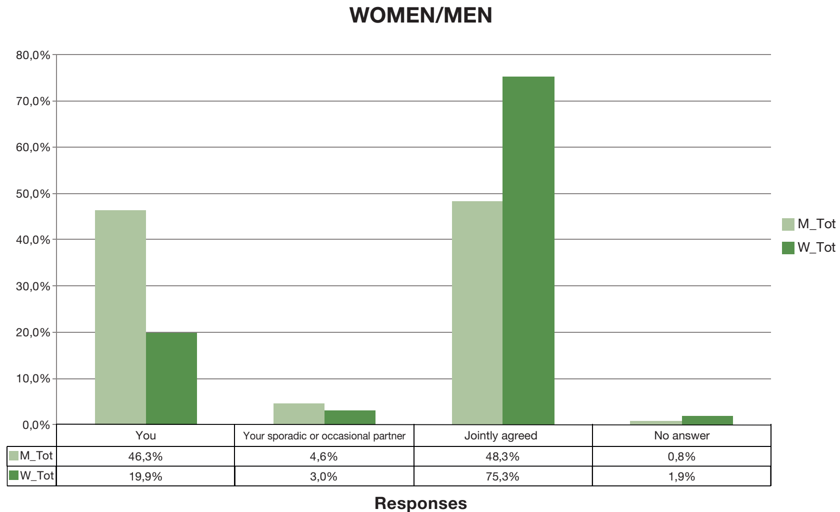
Graph 8. Person who decides to use contraceptive methods, sporadic or occasional partner



	You	Your sporadic or occasional partner	Jointly agreed	No answer
M_Tot	45,4%	7,0%	45,6%	2,0%
W_Tot	27,4%	4,8%	66,0%	1,8%

Source: Own preparation from the ENSS 2009 (MSPS – CIS: study no 2780)

Graph 9. Person who decides to use methods to prevent STI, HIV/AIDS, sporadic or occasional partner



	You	Your sporadic or occasional partner	Jointly agreed	No answer
M_Tot	46,3%	4,6%	48,3%	0,8%
W_Tot	19,9%	3,0%	75,3%	1,9%

Source: Own preparation from the ENSS 2009 (MSPS – CIS: study no 2780)

In addition to data provided by the ENSS and selected to analyse contraception, Autonomous Communities and Autonomous State Cities have participated by means of questionnaires forwarded by the IC. There was also collaboration by the Spanish Contraception Society and the Federation of State Family Planning which gives us an overall view of the situation.

In Spain, the first national campaign strictly on promotion of the male condom performed in 1991 with the slogan ***Póntelo, pónselo*** **[Put in on, Put it on him]**, had major social and media impact. It was aimed at the general population, especially young people, and tackled the prevention of HIV and other STI in addition to prevention of unwanted pregnancies.

The provision of methods to prevent unwanted pregnancies aims to provide information and offer the means to help people decide the time and number of children they wish to have while at the same time enjoying pleasant sexual relations without fear of unwanted pregnancies. To help people take a decision on the most suitable contraceptive method for their needs we need to provide accessible, full and updated information which enables them to choose between existing alternatives and take a proactive attitude, not limited to dealing with the demand for verbalised contraception and always respecting the decision of women. Therefore, access to different contraceptive options is a key aspect to make effective the right of each person to take decisions regarding their reproductive life.

We should not overlook here or throughout this Sexual Health section that, except for the male and female condom, the remaining methods to prevent unwanted pregnancies do not confer protection against STI, including HIV, for which reason their use endangers the sexual health of those who continue to practice coitus. As seen from data provided by the National Sexual Health Survey, stable partners protect themselves less from STI, a fact consistent with that contained in the Multisectoral Plan against HIV infection and AIDS (MSPS) regarding the slow decline in cases of women who, in addition, are mainly infected by heterosexual transmission. In this regard, the low perception of risk is key, especially in women with stable partners or in serial monogamous relationships, who do not perceive risk exposure.

As to how to organize and regulate health services that address the needs of women and men in terms of decisive maternity and paternity in general, the majority of Autonomous Communities have specific protocols and programmes in their portfolio of services. According to the report by the Federation of State Family Planning, some are governed by the programmes "Care of the Woman" and the "Mother-child" programmes from the portfolio of services which establish fundamental matters relating to information and follow-up of methods to prevent unwanted pregnancies, so each centre

operates depending on the implication and will of professionals and based on available resources.

As referred by Autonomous Communities, the majority have specific care protocols. In this regard and considering the report by the Federation of State Family Planning, difficulties continue to occur arising from significant care pressure, reduced time for consultations, personal prejudices of some professionals, and the deficit in health training which hinders the correct approach to deal with the provision and follow-up of methods to prevent unwanted pregnancies. In other Autonomous Communities, there are no protocols agreed for all centres.

In short, actions which Autonomous Communities indicate they perform will materialise by means of actions aimed at women of fertile age, and managed both from primary care centres and specific centres in certain Autonomous Communities with different denominations depending on region such as for example: Centre for Care of the Woman, Family Orientation Centre, Family Planning Office, Units for Care of Sexual and Reproductive Health, etc. In general, what is carried out is information and follow-up of methods to prevent unwanted pregnancies, advice for each one of the contraceptive methods, side-effects, action procedures for emergency contraception (diagnosis, prescription, monitoring, follow-up and/or referral) and awareness actions on sexual and emotional matters, dealing with prevention, diagnosis, and treatment of STI.

Therefore, as for the **care structure regarding contraception,** each Autonomous Community presents a diversified and differentiated map wich may generate inequities in the health system. Differentiation is made between the following classification and operation:

- Communities which have a mixed system where primary care health centres coexist with specific centres which provide sexual and reproductive health care (Aragón, Asturias, Baleares, Canarias, Cantabria, Cataluña, Castilla-La Mancha, Castilla y León, C. Madrid, C. Valenciana Extremadura, Galicia, La Rioja, Murcia, Navarra and País Vasco).
- Autonomous Communities which have integrated the former family planning centres or consultations into primary care health centres in which all care is centralised to prevent unwanted pregnancies with the exception of referrals to outpatient and inpatient hospital care departments (Andalucía).
- Town councils with centres which carried out services for contraception (City of Madrid).

In light of the data facilitated by Autonomous Communities, more often than not primary care teams refer cases to specialised care departments and specific centres. In this respect, it has been identified as good practice primary care centres where care falls on midwifery and/or nursing personnal; this enables to reduce the delay receipt of information and the administration of the method to prevent unwanted pregnancies.

In addition, this service is also provided in specialized care through of the Gynaecology and Emergency Services. Some Communities even have specialised departments to offer sexual health care to young people. As for the kind of predominant approach to facilitate the provision of contraception in primary care health centres, this is characterised in the majority of cases for being too focused on reproduction where there is an emphasis on the care aspect to the detriment of a health promotion approach. However, there are some specific centres (ASSIR, COF, CPF, CAM, UGA, CSSyR)[2] where work is carried out with an integral approach from the point of view of sexual and reproductive rights although this depends to a large extent on initiative, disposition and availability of professionals.

In light of the data collected both by the Institutional Committee (IC) and the Federation of State Family Planning, there is a gender bias over the promotion of sexual health and the way to promote the use of methods to prevent STI and methods to exercise decisive motherhood and fatherhood. There remains a consideration, both by the group of professionals and society in general, that the prevention of pregnancies is something which lies solely upon the women and that the responsibility of men is limited to use condom and vasectomy. The absence of joint responsibility and care of affective bonds and the couple by some men means that women are more concerned with the risk of pregnancy while men are more concerned about the prevention of STI-HIV.

Another matter highlighted by this gender bias is the denomination of centres which deal with the request for contraception. Characteristically, it seems that they are only aimed at women as "Centres for Care of the Woman" or "Programmes for care of the woman".

Another difference between Autonomous Communities is reflected by the composition, provision and operation of professional teams in addition to the functions performed by each professional. According to interviews to professionals conducted by the Federation of State Family Planning, gynaecology,

[2] Different ways of denominating the specific centres: ASSIR (Sexual and Reproductive Health Care); COF (Family Advice Centre); CPF (Family Planning Centre); CAM (Care Centres for Women), UGA (Gynaecological Support Unit); CSSyR (Sexual and Reproductive Health Centres).

midwifery and nursing professionals are currently working; professionals who carry out coordinated work in accordance with consensual protocols although in cases in the absence of these policies they act according to criteria based on cumulative experience. In spite of this, for a large number of professionals, contraceptive care does not form part of their aims or interventionist practice. Consequently, they refer the request or limit themselves to performing the simplest activities such as providing oral contraception. This entails a lack of competence because of the absence of practice and knowledge updates and has, in short, an effect on the quality of care and access to the service.

Even then, there are very good practices in health centres with professional teams implicated in providing quality care and who deal with information, contraceptive advice, dispensing and follow-up of all methods to exercise decisive maternity and paternity, and only refer those tests for which there is no infrastructure or surgical method. Based on the IC responses to the questionnaire, we can establish and note the following requests:

- In **specific centres** information is provided for the selection, advice, and application, monitoring and follow-up of different methods including emergency contraception. In some cases this includes vasectomy and tubal ligation although the majority refer to inpatient hospital care.
- In **specialised or outpatient centres** they deal with referrals from primary care and, in turn, also make referrals, as appropriate, to specific care centres.
- For **hospital care,** with exceptions, they deal exclusively with requests for surgical contraception.

Meanwhile the Portfolio of Common Services of the NHS covers in its Annexes 2 and 3 dealing with primary and specialised care respectively, the following indications in relation to the "woman" and "family planning".

Annex 2 of primary care in section 6.3.2 "Care of the woman" cites textually the "Indication and follow-up of non-surgical contraceptive methods and advice on other contraceptive methods and voluntary abortion".

For its part, Annex 3 of specialised care, specifically section 5.3.7 of "family planning", includes: section 5.3.7.2 the information, indication and follow-up of contraceptive methods including intrauterine devices and section 5.3.7.3, performing tubal ligations and vasectomies in accordance with health department protocols where the possibility of reversing these procedures is excluded.

Territorial variability in sexual health care is noted. There are various Communities which do not consider this a priority area of intervention in their

respective health plans and some of these regulate this care in **specific regulations** focused on aspects related to prevention of STI-HIV and unwanted pregnancies. In relation to the latter, there are seven Autonomous Communities which have specific regulations to dispense methods to prevent STI-HIV[3] and methods to exercise decisive maternity/paternity in the public health network[4]. These regulations relate especially to the availability of condoms, copper IUDs and contraceptive pills for free dispensing in centres themselves.

All Autonomous Communities offer contraceptive methods in accordance with that stipulated in the Portfolio of Common Services of the NHS, although significant territorial variability has been observed for **public financing and accessibility** for contraceptive methods which may generate inequalities and inequities to access them.

In the case of hormonal contraceptives only those covered in the nomenclature for invoicing of official NHS prescriptions are always financed in accordance with the National Health System's financing criteria. In addition, specific criteria according to that set out in the Portfolio of additional Services of Autonomous Communities are also followed. We have to consider as covered in the Portfolio of Common Services of the NHS that these contraceptives are not prescribed as methods to prevent unwanted pregnancies but rather to treat pathologies.

In the case of the male and female (to a lesser extent) condom to prevent STI and specifically HIV, in the majority of Autonomous Communities these are provided free of charge or partially subsidised by means of programmes aimed at specific groups such as young people. In addition, in the majority of Autonomous Communities we consider personalised care and/or care of the couple from primary care consultations such as for example by means of *Consulta Joven* programmes.

[3] Condoms (mainly male)

[4] Regarding contraceptive methods dispensed, we highlight the following: IUD; condom (mainly male); hormonal contraception; intramuscular hormonal contraception; subdermal implant; permanent contraception: Fallopian tube obstruction and vasectomy.

In relation to **emergency contraception**, information provided by Autonomous Communities highlights that there is no common protocol for the NHS which establishes conditions for their provision in health departments; this implies differences as to access, place of dispensing, conditions for their acquisition and weekend services.

In addition, while it is true that full financing of emergency contraception exists in eight Autonomous Communities, in the remainder users assume their cost themselves.

Table 1. **Type of financing for emergency contraception (Levonorgestrel) in Autonomous Communities**

Financing	Autonomous Communities
Partial	Ceuta (Center for short term emigrants) Extremadura and Navarra (hospital emergency rooms and family planning centres)
Total	Andalucía, Aragón, Asturias, Islas Baleares, Cantabria, Castilla y León, Cataluña, País Vasco
None	Canarias, Castilla la Mancha, C. Valenciana , Melilla, Madrid, Murcia, La Rioja

Source: Own preparation from data provided by the Institutional Committee

As highlighted, since emergency contraception is not included among the NHS pharmaceutical provisions, it is not financed by means of official prescriptions in any Autonomous Community preventing their acquisition by prescription of the Social Security System. On the other hand, ten Communities have set up specific provisions with the purpose of guaranteeing more accessibility to this contraception given its emergency nature. In these cases the Health Department for the Autonomous Community purchases drug entries and distributes according to the requirements of each health area; they are administered by professionals of the public health centre to women free of charge.

In May 2009, the Government of Spain announced the implementation of a measure which would enable the purchase of emergency contraception without prescription in pharmacies across the country; this proposal entered into force in September. With this decision Spain is now in a similar situation to other countries in where it is dispensed without a prescription such as France, United Kingdom, Portugal, Belgium, Denmark,

Slovenia, Finland, Holland, Iceland, Luxembourg, Norway, Sweden and Switzerland.

The purpose of this measure is to facilitate access to the emergency contraceptive pill without the need for medical prescription for all women who require this regardless of their place of residence and time period necessary to guarantee its efficacy (up to 72 hours following coital sexual relations which significantly reduces up to the fifth day). For correct use of the emergency contraceptive pill, the MSPS has prepared different explanatory materials which pharmacists will give women who buy the pill each time it is dispensed. Specifically, these materials are[5]: **information on use by users** (with recommendations on the use of the contraceptive pill, mode of action of the drug, possible side-effects, etc.); information on regular use of contraceptive **methods** (with information on barrier and hormonal methods, etc.) and **information on prevention of HIV and other STI**.

Moreover, it is interesting to highlight the different initiatives and agreements which, from the MSPS, have been performed with condom manufacturers just as the information which has been published on the emergency contraceptive pill. The following is of note:

1. *Yo pongo condón* [I use a condom] campaign.
   For further information, visit:
http://www.msc.es/gabinetePrensa/notaPrensa/desarrolloNotaPrensa.jsp?id=1377

2. *Yo pongo condón* [I use a condom] Web campaign.
   For further information, visit:
http://www.yopongocondon.com/

3. Manufacturers and pharmacists undertake with the MSPS to promote use of the condom among young people.
   For further information, visit:
http://www.msc.es/gabinetePrensa/notaPrensa/desarrolloNotaPrensa.jsp?id=1385

4. Pharmacists will inform young people about contraceptive methods.
   For further information, visit:
http://www.msc.es/gabinetePrensa/notaPrensa/desarrolloNotaPrensa.jsp?id=1510

[5] http://www.msps.es/novedades/docs/090911_diaDespues.pdf
http://www.msps.es/novedades/docs/090911_metodosAnticonc.pdf
http://www.msps.es/novedades/docs/090911_SIDA_VIH_ITSEX.pdf

As for **intra and inter-institutional mechanisms,** in some Communities there is notification of correct coordination between the different care levels while in others this coordination does not exist.

When the specific centres are in health centres or hospitals, there is better intra and inter-institutional coordination given that the majority or the entire professional team is shared and the accessibility is facilitated. In some, coordination is achieved by means of clinical sessions and weekly meetings between those coordinating specific centres, health centres and hospital management. In other cases there is only communication during referrals by means of interconsultation based on clinical history or it falls upon midwifery personnel to set up, with monthly meetings, coordination in a same centre. At times, the management sets up a certain level of coordination to work on subprogrammes, where they are available.

The basic team of professionals who deal with methods to exercise decisive maternity and paternity go in harmony with the care level (primary care and/or specialised care medicine, primary care nursing, family planning centres nursing, midwifery and gynaecology) and there are often professionals from NGOs external to health services. In some Communities there are also other profiles such as intercultural mediation, social work, psychology and sexology. It is interesting to note that two Autonomies Communities consider the figure of equality agents in their multidisciplinary teams.

As for functions performed by each professional, the range of situations is also broad and there are considerable differences, in general terms, between primary care centres and specific centres where there are usually specialised multidisciplinary teams. Therefore, the role of each professional in providing contraception is set up based on his/her care level in which it is found, that is:

- Medical personnel, whether primary or specialised care (gynaecologist(s)), inform and impart health education in addition to prescription if required.
- Nursing and midwifery personnel who inform and carry out health care education, set up contraceptive methods with consensual protocols in health care centres and in the Autonomies Community, and collaborate with secondary schools, PTAs and youth and community associations.
- Professionals from other disciplines such as social education, social work, psychology, sexology, etc., who may work in specific centres (for example young people's consultations), inform about devices and collaborate with secondary schools, youth associations, PTA's, etc.

2.4. Strategic aims and lines for sexual health

Strategic lines define what actions and mechanisms are required to plan and set up to achieve a determined aim and improve a certain situation. The justification of these strategic lines is based, first, on the theoretical framework in which sexual health is taken as a human right from a holistic and integral approach and second, the analysis of the sexual health situation in Spain in which key matters in relation to organisation, resources, services and programmes related to this have been reported.

We have also considered data provided by the National Sexual Health Survey which offers privileged information from a gender viewpoint on the opinions of the population over 16 in relation to experiencing their sexuality and sexual health care they received from health services.

Finally, to enrich the information we have had relevant investigations from the MSPS, the Institute for Youth and Professionals Associations of Sexology, among others. Moreover, other studies by professionals have been considered in addition to other sources cited in the bibliography.

With all this theoretical backing the aims and recommendations of the strategic lines, based therefore on the detailed analysis and systematisation of the different information sources referred, have been defined.

Transversal aspects to consider in the strategic lines

When dealing with the aims and recommendations of each one of the sexual health strategic lines, we have to consider the incorporation of the different contexts and/or circumstances which may place men and women in a more vulnerable situation, and as such they may be subject to modification if circumstances which produce them change.

Below, we highlight the most relevant circumstances that should be considered as long as there is reference to the "contexts of vulnerability" in the aims and recommendations from the sexual health section. In addition, special attention needs to be paid to those other biographic situations of men and women regardless of their sexual options and orientations and gender identities which may be affecting the experience of their sexuality and exercising their rights.

Categorising and classifying the different contexts of vulnerability by specific situations deal solely and exclusively with a didactic resource for its best interpretation, but we should not overlook the interaction which may occur from the different variables which cause multiple inequalities in a same

person, and they will have to be dealt with from this perspective both regarding the design of policies and programmes and in health care.

We will always have to consider, as we have been doing in developing the sexual health section, the different requirements of men and women both for the strategic lines and the following contexts of vulnerability.

Age groups: children/youth and older persons

We have to consider that sexuality during subsequent stages of life will be based on the way in which sexuality has been experienced during childhood and adolescence. Being able to establish satisfactory emotional bonds during this period will facilitate a reference for harmonic development during adulthood.

Considering some studies by the Spanish Council for Youth it has been observed that young people have a major capacity for learning and handling their health and sexuality but in turn they have a series of information, educational and skills development deficiencies which at times leads to their sex life either not being enriching, not helping them to get to know themselves, accept themselves and enjoying what they do. In this sense regarding the young LGTB population, the process of self-acceptance and explanation of their sexual options and orientations and gender identity they should undergo places them in a more vulnerable position with a risk of low self-esteem and difficulty negotiating their initial sexual relationships and practices.

The factors which determine the adoption of preventive measures for sexual relationships indicate that having correct information on STI-HIV and their mechanisms of transmission and prevention is necessary but insufficient. We must first consider the differential gender socialisation and in addition other factors such as perception of risk, romantic ideals, communication and negotiation skills, the eroticisation of the condom, self-esteem, influence of the peer group, matters associated with various stigmas such as, for example, homophobia, etc.

Therefore, the young population encounters difficulties accessing health services, among other reasons, because of difficulties communicating and lack of appropriate information; the visibility of the resource and fear of not having privacy; time restrictions over access to services; the lack of recognition of sexual rights of this young population; the inhibition of professionals and consequent referrals; restrictive interpretations of consideration of maturity of young people and lack of knowledge of patient autonomy regulations. This worsens in rural situations and when dealing with the disabled. In the case of young LGTB people, because of the lack of training on sexual and gender diversity of health professionals, the fear of being rejected is added to these difficulties.

Another age group that might also be susceptible to vulnerable situations because of the major interindividual and contextual variability is the group of elderly men and women regardless of their sexual options and orientations and gender identities. We need to consider that these people have been adapting to several changes throughout their life and that there are factors which determine their quality of life and sexuality, such as state of health, level of autonomy, socioeconomic level, maintenance of cognitive functions, having a partner or emotional and family support, among others.

Disabilities

As indicated by Article 5 of Organic Law 2/2010 of 3 March on sexual and reproductive health and voluntary abortion, public authorities when setting out their health policies will guarantee elimination of any form of discrimination with special attention to people with some form of disability whose sexual and reproductive rights are guaranteed; the necessary support based on their disability will be established for them.

One of the most extended patterns in the traditional viewpoint of disability has been believing they have no sexual needs since the existence of deep-rooted taboos in our culture has significantly limited the possibility of fully developing their sexuality. The sexuality of disabled people is characterised by social prejudices over different bodies and minds. The prevailing norm often considers them as undesirable and undesiring hence the importance and insistence from this Sexual Health section is in relation to making diversity the norm and not the exception.

The exercise of disabled persons' sexual rights is demanded from associations which represent disabled people regardless of their sexual options and orientations and gender identities; this is often hindered by excessive overprotection of carers in addition to health personnel. These attitudes at times lead them to adopt an extremely protective attitude with disabled people which hinders them from enjoying freedom and autonomy. As recognised by conventions to protect disabled people, sexual and reproductive health services should have trained personnel, accessibility mechanisms, specific and specialised materials which eliminate these inequalities to avoid situations of discrimination.

Disabled people have the right to access emotional-sexual education to be able to experience this healthily. They should gain knowledge on functioning of the body, how pregnancy occurs and how it can be avoided, how to make sexual relationships more communicative and pleasant, identifying abusive practices and seeking out strategies to tackle them or how to avoid STI-HIV. Depriving them of sexual education means making them more vulnerable. This

information should be available in accessible and different formats which guarantee their suitable reception, having facilitated their active participation in their development.

Lesbians, gays and bisexuals

In 1973 the American Association of Psychiatry (APA) decided to eliminate homosexuality from the "Manual for Diagnosis of Mental Disorders" and encouraged rejecting any legislation discriminating against gays and lesbians. This was only the first step in a slow process of change which would take time to reach the rest of the world as we would have to wait two more decades until 1990 for the World Health Organization (WHO), to remove homosexuality from its list of mental diseases.

Society's homophobia is recognised by international institutions as one further manifestation of gender violence. In a sense, the inexistence of gay, lesbian and bisexual referents within sexual education creates an information and education deficiency among the population as a whole which reinforces both social and internal homophobia, and has an effect on the lack of knowledge of one's choices and orientations of sexual desire to acceptance of these.

According to the ENSS, attitudes which question heterosexuality as the norm and the conventional and dominant place are observed. Data initially reveal a heterosexual pattern; while 4% of men and 2.7% of women refer to having stable relationships with partners of the same sex. Even then, the possibility of a change in sexual option over life is accepted by virtually half the population surveyed who report "strongly and considerably agreeing" with this statement both men (49.4%) and women (50.2%) especially in the age group 16 to 44. In the contrary case, men and women report "strongly and completely disagreeing", especially those 55 and above (30% for both sexes).

For the majority of those surveyed "sexual relationships between two men is a respectable option" but 23.4% of men and 18.2% of women report "strongly and completely disagreeing" (especially those over 55). For "sexual relationships between women" the most disagreement is found among men older than 65 who "strongly and completely disagree" in 48.1% of cases.

The opinion that "homosexuality is an illness" is starting to become minority although there is still a considerable percentage of men (17.8%) and to a lesser extent women (41%) who agree with this statement. This opinion is more common in people 55 and over.

Latent homophobia and biphobia in society continues to cause problems of self esteem and self acceptance in some people whose sexual options and orientations do not concur with heteronormativity.

Transsexual men and women

Transsexuality is not associated or dependent on sexual options or orientations, that is, there are bisexual, homosexual, heterosexual, transsexual men and women. Probably one of the claims pending for the transsexual community and different movements to defend human rights is the social awareness that transsexuality is not a threat, or aberration, or a disease, that is, the fight against the discrimination generated by transphobia.

From a legal and social standpoint, transsexuals usually claim two rights. The first is more facility to modify legal sex and the second, integral health coverage. Regarding legally recognised sex, in Spain, Law 3/2007 of 15 March which regulates rectification of registering the sex of people enables modifying mention of sex in official documents including the civil registry and national identity document as long as the requirements set out in law are complied with.

One of its historical claims is based on the importance of the health system to perform hormone therapy and sex change operations. In 1989, the European Parliament encouraged member states to facilitate the access of transsexuals to integral health care although the Psychiatric Diagnostic Manual DSM-IV-TR still classifies transsexuality today as disorders of sexual identity. In the Spanish public health system there are at least five specialised units for care of gender identity and sexual change: Hospital Carlos Haya de Málaga in Andalucía, Hospital Ramón y Cajal in Madrid, Hospital de las Cruces de Barakaldo in País Vasco, Hospital Clínic de Barcelona in Cataluña, Hospital de San Agustín de Avilés del Principado de Asturias.

We should not overlook, as covered by the Multisectoral Plan to respond to HIV infection and AIDS (2008-2012), that transsexual women are particularly vulnerable because of some of their sexual practices and the same socioeconomic and cultural factors of the remaining women; this is also interrelated with the impact of stigma from the transphobia they suffer.

People living with HIV

One of the most serious consequences of the HIV/AIDS epidemic is the stigma and discrimination suffered by people living with HIV; discrimination that threatens their dignity as people and which therefore represents a violation of their human rights. This discrimination, in addition, is a major obstacle to the treatment and prevention of HIV as it may act as facilitating risk behaviour because of fear of recognising seropositivity, fear of undergoing the HIV test, and hiding risky practices by people found to be in more vulnerable situations.

In addition, difficulties in the area of sexuality are usually frequent and caused, among other reasons, because of the impact of side-effects of some antiretroviral treatments on body image, the anguish arising from diagnosis, side-effects of treatments, fear of rejection and abandonment, feeling of guilt or fear of transmitting the virus or reinfection, which may have a significant impact on the quality of life and capability to enjoy and participate in a desirable sexual relationship. Women are more vulnerable to HIV infection than men because of biological, socio-economic and cultural factors. Inequalities of power entail limited control of means of prevention and hinder the perception of risk against STI and HIV. Therefore, at times, women see their capability to exert control over their sexual and reproductive health as limited. In addition, the impact of sexual violence and its different expressions is one of the most important causes to increase this vulnerability.

Migration

The social, economic and cultural reality of people is also present when experiencing sexuality. Aspects such as self esteem, beliefs about love and relationships or situations of solitude and isolation have a key influence on the sexual health of the Spanish and immigrant population. This, together with the specific characteristics of migratory processes, at times may mean that immigrants encounter barriers which hinder their access to information and treatment from STI-HIV and unwanted pregnancy prevention services; this information should not be underestimated considering the levels of voluntary abortion according to nationality, and HIV epidemiological data[6].

Migration is a social asset which should be considered not as a problem but rather an opportunity for enrichment by all the parties involved. Therefore, active participation of migrated people in formulating public policies is fundamental to the success and sense of belonging of these when adjusting to the diversities existing in each country. Therefore, we need to consider the different realities of immigrants depending on their countries of origin, culture and ethnicity.

According to the study performed by the Federation of State Family Planning, these difficulties are motivated at times by lack of knowledge of their rights, structures, ways to access resources and prevention and treatment methods; the perception of public institutions more as a threat than as a source of protection, the difficulties with various languages both by the immigrant population and health services and lack of support networks. We also need to

[6] According to the annual report by the MOH and Social Policy in 2008, 55.1% of the women who underwent a voluntary abortion were not of Spanish nationality.

consider people in irregular situations from an administrative point of view as this doubtless hinders exercising their rights as citizens.

Sexual violence

Sexual violence is defined in the *Global report on violence and health* by the WHO as:

> *"any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work".*

Sexual violence includes sex under coercion of any kind including use of physical force, attempts to obtain sex under coercion, aggression by means of sexual organs, sexual harassment including sexual humiliation, forced marriage or cohabitation including marriage of minors, forced prostitution and commercialisation and trafficking of girls and women, forced abortions and pregnancies, denying the right to use contraception or adopt measures to protect against infections and acts of violence which affect the sexual integrity of women such as female genital mutilation and inspections to verify virginity. These aggressions are deep-rooted in sexual inequality and relationships of power and are in turn one of the most heartrending manifestations of this.

Sexual violence makes women defenceless and leads to major difficulties looking after their sexual and reproductive health. For women who find themselves in an abusive relationship the risk of HIV infection and the possibility of having an unwanted pregnancy considerably increases because of fear of the consequences of opposing an unwanted sexual relationship, fear of rejection if they try to negotiate safer sexual relationships and the coercion and emotional manipulation to which they are subjected. On the other hardy, the same diagnosis of HIV infection or the news of a new pregnancy are in themselves risk factors to increase the sexual violence suffered by women. In addition, they have other significant consequences for health including suicide, post-traumatic stress disorder, other mental illnesses, unwanted pregnancies, self-inflicted lesions and in the case of sexual abuse of minors, the adoption of high risk conducts such as having multiple sexual partners, consumption of alcohol and drugs, deteriorated self-esteem and less capacity to negotiate sexual activity.

The actual scope of sexual violence is unknown as, on the one hand, there are few investigations and, secondly, this is under reported by abused persons

although the data reviewed to prepare the *Global report on violence and health*, suggests that one in five women may suffer sexual violence by their trusted partner throughout their life (WHO).

On the other hand, there are numerous investigations such as the study *"Sexual abuse during childhood and adolescence: long-term effects on sexual and reproductive health and emotional and sexual relationships of adult women"* performed by psychologists and professionals from sexual and reproductive care units in Catalonia and financed and published by Rubí town council and Barcelona regional council. This study reveals a high prevalence of sexual abuse during childhood and adolescence accompanied by a high percentage of physical aggressions. It has also been observed that these situations of continued abuse are linked to the negative perception of women over their health and sexual health. Moreover, as mentioned on other occasions, a large number of women do not verbalise the situation they underwent during childhood because of various fears, which are products of the abuse itself.

In Spain, the Woman's Institute provided data from 2007 collating 6845 reported cases of abuse, sexual harassment and aggressions, of which 55.9% were aggressions with or without penetration. The same year, 6904 cases against sexual freedom and identity were reported, and the Guardia Civil also declared 15,537 women to be the victims of prostitution in 2007, 98.24% of them were foreigners.

Another violation of human rights is human trafficking for sexual exploitation. As indicated by the Integral Plan to Respond against Human Trafficking for Sexual Exploitation Purposes (2009-2010)[7], this covers prostitution, sexual tourism, purchasing brides by postal mail and servile marriages; these are one further manifestation of the situation of inequality in which women and girls find themselves in many places in the world and are a clear expression of sexual violence.

Within the analysis of human trafficking in Spain, it is impossible to avoid such a relevant connection of this phenomenon with prostitution so this should be taken into account when intervening in sexual health by health services. In this sense, we need to consider the risks to sexual health produced mainly by requests for lack of protection by men who demand paid sex, establish measures to reduce damages with prostituted women and women in human trafficking situations, in addition to considering the consequences for health arising from abuse and aggressions.

[7] http://www.migualdad.es/ss/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobheadername1=Content-disposition&blobheadervalue1=inline&blobkey=id&blobtable=MungoBlobs&blobwhere=1244651910209&ssbinary=true

The ENSS asked interviewees about two issues related to sexual violence; first, whether at any time throughout their life they had maintained sexual relations against their will (understanding these relations to be consented but unwanted) and second, whether they had suffered from sexual abuse and/or rape (understanding this as any unconsented sexual activity).The results were the following:

- Sexual relations against their will is a fact which mainly affects women. Somewhat more than 7.4% of women interviewed, compared to 3.5% of men, recognised having suffered from this abuse at least once. Going a little further into depth, the data reveal that it is a fact which occurs in the case of women with a man (91.7%) who, in addition, is usually their stable partner (64%); while, in the case of men, this was with a woman (56.4%) who is their stable partner (31.4%) or another man (12.6%).
- Regarding the incidence of sexual abuse, the data indicate that: women surveyed recognised having suffered from abuse once (2.9%) and more than once (2.3%) while men state having suffered abuse "once" to a much lesser extent (1.1%). In the same context, women have had relations against their will more than once (5.0%) compared to men (1.4% "once"). As for the sex of the person carrying out the abuse or assailant, regardless of the sex of the person who has been abused, there is agreement that this is mainly a man (in virtually 83.2% of cases). In cases of abuse or violation of women the aggressor was a man (88.8%) and for a man it was another man (65.4%) or a woman (26.8%). In the case of women they are usually family members or acquaintances (25.3% and 26.6%) and in the case of men acquaintances (46.2%) or strangers (23.0%).
- As for paid sex, the data confirm that it is almost virtually men who state having paid for sexual relations: once (10.2%) and more than once (21.9%). By age groups, this is especially men 35 and over (25.7%). It is significant that this is a practice with quite a notable incidence also among young people aged 25 to 34, an age group for which these figures represent 18.3%.

In short, situations related to sexual activities against their will, abuses and/or cases of rape are alarming in that they speak of the vulnerability of the human rights of a person generally within their family environment, surrounding circle or partner. In all cases, both men and women highlight that it was a repeated fact which hindered not only preventing aggressions and reporting them but that this also usually generates contradictory feelings triggered by the loss of the emotional bond combined with feelings of shame and guilt.

General Aim

Promote quality care with accessible sexual health services contributing to improve the experience of sexuality in an integral, autonomous, diverse, egalitarian, pleasant, responsible, healthy and respectful way throughout life where the sexual and reproductive rights of men and women regardless of their sexual options and orientations and gender identities are guaranteed.

2.4.1. Promotion of sexual health

Health Promotion is the process which enables people to increase their control over health determining factors and consequently improving health. In this sense, health promotion is an overall political and social process which encompasing not only actions aimed directly at strengthening the skills and capabilities of people, but also those aimed at modifying the social, environmental and economic conditions with the purpose of mitigating the impact on public and individual health (WHO, 1998).

Sexual health is a central component for the health and well-being of people; therefore, promoting sexual health implies favouring conditions so that health services guarantee their quality by offering information, advice and care on any aspect related to sexuality and reproduction.

We start out from an integral approach to promote sexual health which guarantees the sexual rights of men and women aimed at favouring changes in relation to gender bias and encouraging for example joint responsibility of people within sexual relationships regardless of their sex and sexual options and orientations; that is, both men and women are responsible for experiencing sexuality in a satisfactory, pleasant and equal way.

As revealed in the results from the ENSS, the ways to experience sexuality express social relationships of inequality between men and women and we note that these are still marked by traditional gender stereotypes and roles which determine the role of men and women in sexual relationships.

In addition, according to results obtained from the ENSS, we are faced with a persistent model of sexuality highly conditioned by stages of the life cycle which mainly characterise sexuality in the central ages of reproduction especially for women far removed from an integral model of sexuality developed over life.

Sexual information and education

When speaking of information, reference will be made to the action of communicating knowledge which enables broadening or specifying that already have on a certain topic. Going one step further, by education we understand multidirectional processes of socialisation (formal and informal) by means of which we convey knowledge, values, customs and determined ways of acting for men and women from a specific society. Therefore, integral, egalitarian and respectful information and education will be a fundamental tool to promote people's sexual health and well-being. By means of this, men and women may autonomously decide on their sexual and reproductive life, from childhood to old age.

The possibility of having quality education and information on sexuality enables experiencing this freely without fears of prejudices, based on communication, respect and pleasure, in addition to having the capabilities and resources to prevent STI including HIV and unwanted pregnancies.

Awareness and information campaigns carried out are mainly focused on prevention of risks associated with sexual behaviour rather than the construction of cultural and symbolic references which favour an integral and holistic concept of sexuality and which therefore generate an area for healthy sexuality to be practiced. Among young people, due to the differential gender model of socialisation, traditional sexual patterns are still present which although inserted into a contemporary social context manifest differently and reproduce similar relationships of power and subordination.

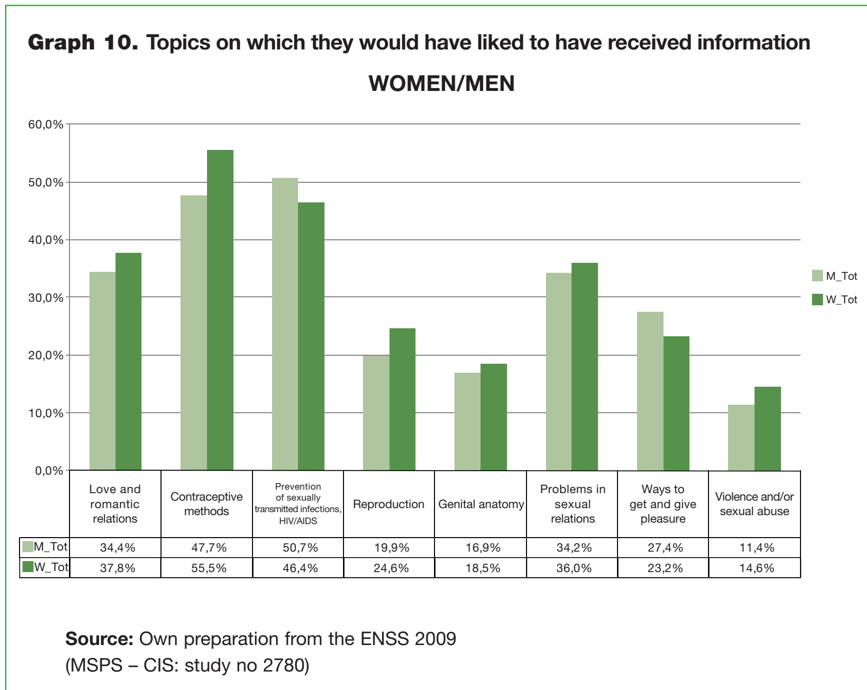
The ENSS detects that although the information provided on sexuality is assessed as suitable, this is deficient for some topics. With the purpose of fully adapting information to the needs of the population, it will be necessary to complete this with other aspects requested by both sexes. Half of men and women coincide in assessing the information they have on sexuality as good, somewhat more for men (60.5%) as compared to women (53.8%).This assessment reveals significant variations based on age. For older ages, the lower the assessment of information received; people 55 and over gave the lowest assessment. This highlights, as expected, the greater availability of information related to sexuality in the last few decades.

Regarding information they would have liked to receive, requests differ among those manifested by men and women, that is:

- The request for information on women is initially related to contraception (55.5%) and prevention of STI (46.4%) in all age groups. They would have liked to have information on prevention of STI and HIV initially (50.7%) followed by contraceptive methods (47.7%).

- As for aspects related to sexuality and emotional relationships, men and women manifested they would have liked to receive information on “love and sentimental relationships” in 34.4% and 37.8% of cases respectively although for women this increases to 51% as of age 65. Secondly, 36.0% of women and 34.2% of men would have liked to receive information on “problems with sexual relationships”. As can be seen, for all options similarities can be observed except in the use of contraceptive methods differentiated by sex.
- Regarding the remaining topics on which men and women would have liked to have information, there are no significant differences between both sexes; highlighting content such as “reproduction”, “ways to obtain and give pleasure”, “genital anatomy”, “sexual violence and/or abuse”.

Graph 10. Topics on which they would have liked to have received information



Source: Own preparation from the ENSS 2009 (MSPS – CIS: study no 2780)

In this context, the group of health professionals and in particular primary care, have a privileged space not only to offer information and care to adults on sexuality but also to provide longitudinal sexual education to children and adolescents in the framework of promoting healthy habits and early detection of problems in childhood given the conditions of trust, communication and coordination with families and children or adolescents (de la Cruz, Fernández, Bataller, 2008). In addition, the necessary conditions to collaborate between

public health and the field of education, with the purpose of offering sexual education to the young population, are present.

Participation of users

A participatory approach over public management facilitates the affected population becoming mainly involved in work processes at the same time as increasing the capability of people to organise themselves with the purpose of finding alternatives and solutions to problems affecting them (Schwartz and Deruyttere, 1996). Participation is closely linked to the efficacy of public policies as they will be positioned closer to achieving their aims, thereby generating a high impact if they have been identified, designed, implemented and assessed from the viewpoint of social participation.

In this sense, the WHO (2001) highlights that a democratic and participatory management of health centres implies creating a setting in which professionals feel they have a voice in taking decisions and they are treated with respect. If this occurs, it is more probable that in turn they treat users with respect and recognise their rights; in this specific case, sexual rights.

Within a representative formal democracy such as ours we are seeing a growing interest in favouring involving the population in planning health services with the purpose of improving their operation. This perspective is covered in the Law on Cohesion and Quality of the National Health System, Law 16/2003 of 18 May where the general aim of the Health Information System of the NHS is to meet the needs of various groups including, among these, citizens and health organisations and associations including patient and family associations, NGOs which act in the health field, and scientific societies.

Therefore, one of the relevant aspects in knowing the requests of the population in general and certain groups in particular is communication and dialogue with the organised civil society in the sense that they represent the interests of these groups, those who have claimed responsibility for promoting human rights and sexual and reproductive rights.

Finally, the reflection on sexuality may also be a way of performing a creative rupture with mechanisms restricting identities, those defining unequal gender roles and which encourage social relationships marked by domination. Mixed areas for consensus between different population groups such as for example young people, adult women or people living with HIV, among others, may be a potential transformer which should be used to create more positive ways of experiencing sexuality both for men and women, regardless of their sexual options and orientations.

Aims to promote sexual health

1. Facilitate information and education on sexual health for the population from a holistic point of view considering sexual relationships in addition to specific needs and/or situations of different population groups and different contexts of vulnerability (age groups, disabilities, sexual options and orientations, gender identities, people living with HIV, migration, sexual violence).
2. Promoting and encouraging channels of social participation in health policies related to sexual health.
3. Promoting taking decisions freely and in an informed way as regards maternity and paternity.

Recommendations

1. Actions will be taken to promote healthy, pleasant and equal sexuality throughout life considering the different life circumstances of men and women.
2. Determining social, cultural, economic and gender factors will be considered in actions to promote sexual health making different contexts of vulnerability in different population groups visible (age group; disabilities; sexual options and orientations; gender identities: transsexuality; people living with HIV; migration; sexual violence).
3. Actions will be designed to encourage joint responsibility and equality in sexual relationships and the use of contraceptive methods and prevention of STI regardless of sexual option and orientation.
4. Information strategies will be designed which strengthen sexual health experienced in an integral, autonomous, equal, pleasant and respectful way where sexual and reproductive rights are guaranteed.
5. Tools will be designed which cover the requirements and different realities of men and women to improve the quality of health intervention, promotion, research and training on sexual health considering social and gender determining factors in addition to the different contexts of vulnerability and diversity.
6. Integral health education and information will be driven forward from a gender perspective for all population groups so that from an integral knowledge of sexuality they can responsibly manage themselves throughout their life.

7. Within the framework of education, sex education during childhood and adolescence, in accordance with the level of development of each age, taking a holistic viewpoint of sexuality and diversity as a reference, will be encouraged.
8. Actions aimed at preventing unwanted pregnancies and prevention of STI considering different vulnerable situations, will be designed.
9. Awareness actions which enable preventing different manifestations of sexual violence as indicated by the CEDAW, and Organic Law 1/2004, of 28 December on integral protection measures against domestic violence, in addition to the remaining prevailing regulations, will be encouraged.
10. With the purpose of optimising resources and sharing knowledge on the promotion of sexual health, there will be joint and coordinated action with the administrations responsible for education, equality, youth, work, immigration, justice, etc., in addition to social organisations.
11. Areas for political dialogue will be developed between public administrations and civil society, organised to take decisions on promoting sexual health.
12. Areas for meeting and reflection on sexuality aimed at different population groups, considering diversity and vulnerable situations, will be promoted.
13. Actions which involve the media in promoting sexual health, considering and bringing to light the different realities of population groups and their contexts, will be undertaken.
14. Actions to enhance the knowledge of sexual and gender diversity and equality and respect for lesbians, gays, transsexuals and bisexuals, will be undertaken.

2.4.2. Sexual health care

Sexual health care is a human right and as such has to be guaranteed by providing quality care for the entire population. This Strategy begins from the integral health care model which involves recognising its multidimensional nature (biological, social, political, financial, geographic, social, cultural and psychological) and the integration of multiple and different life contexts and/or life and vulnerable situations.

In this sense, it is considered that some quality health care services should develop the necessary strategies to provide care which considers not only the biological aspects of health but also the structural, social and psychological aspects which are all fundamental to tackle the sexual health of men and women.

Planning health interventions requires paying attention to factors which do not necessarily limit the quality of health services management. Therefore, the social and gender-related determining factors of the population in relation to sexuality should be specifically considered and appropriate action should be planned to tackle them (WHO, 2001).

According to the analysis of the situation on sexual health care and contraception in Spain performed with Autonomous Communities, some have protocols which set out guidelines for the provision of services and measures to alleviate problems over access.

Most Autonomous Communities refer to considering gender-related determining factors in their sexual health care programmes, although at times they refer to specific actions aimed at women.

According to the same source, measures implemented to promote some safe and healthy sexual practices are mainly focused on the young population. For groups in vulnerable situations such as disabled people, the immigrant population, people who live in rural or impoverished areas, people from various LGBT groups and those who practice prostitution, there are less specific initiatives.

Principal problems and concerns of the population on sexual health

A variety of problems related to sexual health have been identified from the field of sexology; it is considered that these may be seen from primary care consultations or specialised units from the viewpoint of the right of people to fully experience their sexual relationships in a satisfactory way (Bataller, 2006). These problems are usually produced by various factors, both psychological, socio-educational and biological. They are generally interrelated and as such integral solutions have to be considered from the different disciplines.

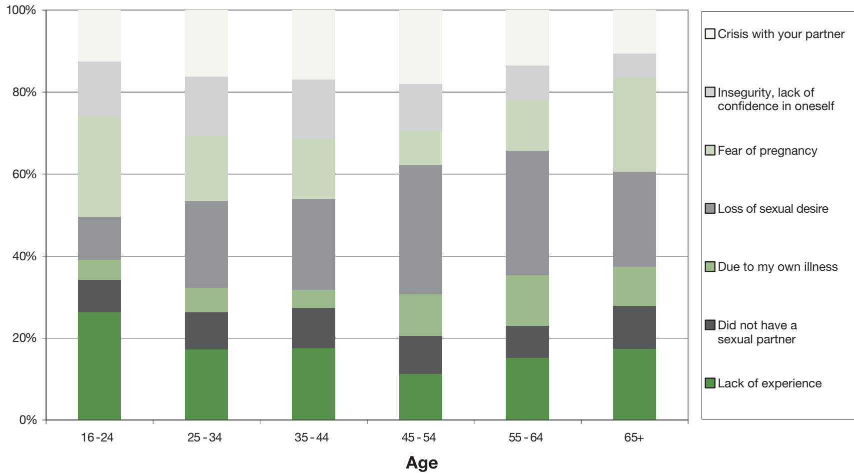
On the other hand, there are problems and concerns related to sexually transmitted infections, unwanted pregnancies, contraception during different stages of life, domestic violence including sexual violence, sexual and gender identity, conflicts and/or discomfort in experiencing sexual options and orientations and also those other difficulties related to sexual eroticism, communication and feelings.

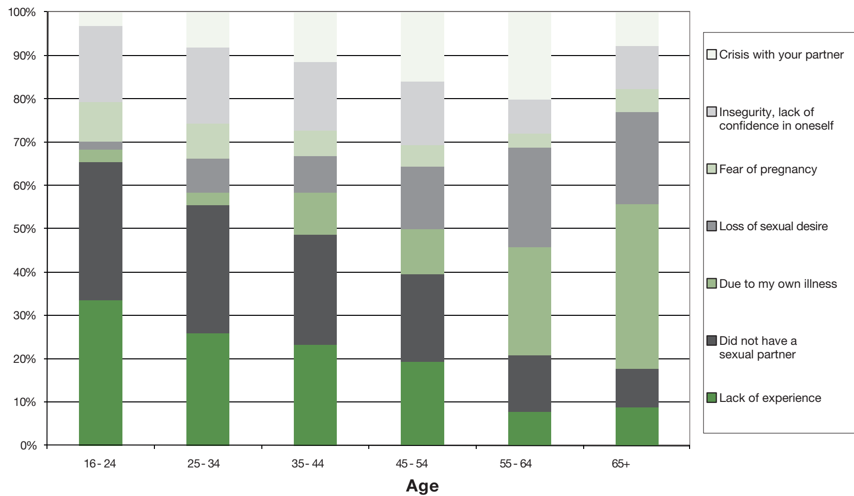
According to information collected by the ENSS, 24.8% of the population surveyed states having felt concern over their sexual life at some point in their life; this concern is related to the following reasons:

- First, the common reason for both sexes is the "lack of experience" to a greater extent for young men followed by young women.
- Secondly, men show concern over "not having a sexual partner", "insecurity and lack of confidence" and "having a disease". Women on the other hand associate concerns over their sexual health with "loss of sexual desire", "fear of pregnancy" and "crisis in the couple".
- Of the people who have felt concerned by their sexual health (24.8% of the sample) most of them indicate "not" having sought help although women have done so more frequently than men. Those who have sought help have used resources which reveal a very similar selection pattern by sexes: most mention having resorted to professionals followed by friends, the partner and the mother.
- As for kind of professional consultations referred, clear differences were observed by sex: men used the service "family doctor", "urology", "psychology" and "sexology" more frequently and in this order, while women attend "gynaecology", "psychology", "family medicine" and "sexology". The degree of satisfaction revealed by care received at consultation is high and quite similar in men and women by age groups.

On the other hand, according to a study performed by the Spanish Federation of Sexology Societies in 2004 on sexual attitudes and habits in Spain, it was observed that 34% of the people interviewed manifested having had a sexual health problem related especially to "lack of appetite or interest in sexual relationships". Almost half these people stated not having consulted any source to resolve their problems because of "thinking it was nothing serious", "considering it was a problem to do with the doctor", "believing it was normal for their age" and "feeling uncomfortable when talking about these topics".

Graph 11. Reasons for concern over sexual life





Source: Own preparation from the ENSS 2009

(MSPS – CIS: study no. 2780)

Therefore, it seems that sexual health problems or concerns are more to do with human relationships than biological pathologies. To understand and tackle these situations it is necessary to do so from a gender perspective and avoid defining as anomalies, deviations, diseases and/or pathologies anything that does not concur with the prevailing dominant patterns in a determined time and place (Esteban, 2006; Sanz, 2007; Tieffer, 1996). Some authors talk of any change in sexology such as Fernández de Quero (2007), when he manifests that *sexology needs to renew its theoretical discourse to propose advances in knowledge of human sexuality beyond dysfunctions and its healing,* at the same time proposing a discourse less medicalised and integrating of the cultural and social dimension of sexuality.

Early detection and care of violence during sexual relationships.

Sexual violence as a manifestation of gender-based violence is difficult to measure for different reasons ranging from recognition by the people who suffer this to mechanisms to identify it.

The ENSS contains some information to consider regarding suspicion and prevention of sexual violence situations. For example, 27.4% of women age 35 and older declare having thought at times whilst they had a sexual relationship: "for it to end as soon as possible". Along the same lines, 6.5% of women aged 35 to 44 who declare having been concerned over their sexual life, refer to maltreatment, abuse and aggressions as reasons for this concern.

The health system plays a fundamental role in quick detection and care of sexual abuse of children in collaboration with the education system. According to Casaubón (1998), programmes can be set up which help to reduce the vulnerability of children to the risk of suffering from sexual abuse (an aim related to primary prevention) and encourage them to disclose cases of abuse when these have occurred (aim associated with secondary prevention).

Another fact noted according to the Bridge report on gender and sexuality is that the disabled, especially women, are also more vulnerable to various forms of sexual abuse in educational, work and health centres as well as within families. This, together with their difficulties to report these situations, place them in more vulnerable positions. (Ilkkaracan and Jolly, 2007).

In addition to working on the detection and care of different manifestations of sexual violence mentioned above, it is necessary to watch out for a series of signs and symptoms which may lead us to think of a possible situation of abuse, for which reason health personnel should be familiar with them

to be able to identify them (consult the Common Protocol for health action against domestic violence, MSPS)[8].

Aims for sexual health care

1. Promote sexual health care in different care fields based on quality, equality and a gender-based approach within the framework of sexual and reproductive rights considering the different contexts of vulnerability and diversity.
2. Improve accessibility to contraception under the same conditions as pharmaceutical benefits with public financing, and prevention, diagnosis and treatment of STI, also taking into consideration its financing and providing information, sexual programmes and sexual health services (Organic Law 2/2010)

Recommendations

1. Quality health care based on the needs of men and women and considering social and gender determining factors, will be encouraged.
2. Actions necessary to improve the accessibility of women to health care will be promoted; there will always be consideration of more vulnerable situations considered in the transversal aspects of the Sexual Health section of this Strategy.
3. Universal accessibility to effective clinical practices for planning reproduction by means of the incorporation of latest generation contraceptives whose efficacy has been guaranteed by scientific evidence in the Portfolio of Common Services in the NHS (Organic Law 2/2010), will be improved.
4. Aspects related to sexual health in accordance with the aims of the Strategy, such as the biography, consultancy on contraceptive options and prevention of STI, early prevention and detection of sexual health alterations, in addition to situations of sexual violence, will be included in the clinical interview.
5. There will be agreement on a Portfolio of Common Services for sexual health care based on that established by Order SCO/3422/2007, of 21 November, by which the procedure for updating the Portfolio of Common Services of the National Health System is implemented.

[8] http://www.msc.es/organizacion/sns/planCalidadSNS/pdf/equidad/commonprotocol.pdf

6. Public preventive-care resources especially designed for the young population with the purpose of promoting autonomous, diverse, egalitarian, pleasant, healthy and respectful sexuality throughout life where the sexual and reproductive rights of men and women are guaranteed, will be consolidated and/or created.
7. Protocols for the provision and handling of contraceptive methods in the NHS which ensure integral and homogeneous and quality action in all Autonomous Communities will be articulated.

2.4.3. Training professionals

Professionals are essential actors for the promotion and care of sexual health in an integral way. In addition, they may contribute to a larger extent to break with the gender stereotypes which contribute to experiencing full and satisfactory sexuality by men and women. According to the WHO (2001), it is necessary to train professionals specialised in sexual health as, because of the obvious link between reproductive health and human sexuality, it has often been supposed that dealing with the reproductive aspects of health was sufficient to meet the needs posed by sexual rights, which is not the case.

Although nursing programmes tangentially include some content on sexuality which increases in the midwifery speciality, it is true that there still remains insufficient university and lifelong training of health personnel, especially medical personnel, on this subject. This hinders professionals from different care levels being able to facilitate integral and quality sexual health care.

For most health programmes and portfolios of services, mentioning human sexuality is barely limited to the information on reproductive aspects, contraception and prevention of STIs in young people. Paediatricians and nurses need to be more involved in this field (Bataller, 2008).

Faced with this limitation from university and lifelong training, in questionnaires forwarded by Autonomous Communities, we observed that virtually all of them offer their professionals training programmes on sexual health care; primary care departments provide the most training followed by specialised care. Some Autonomous Communities also have training programmes aimed at emergency care professionals, in addition to external personnel.

Lifelong training is principally aimed mostly at medicine, nursing and midwifery personnel which is assessed given that they are the first point of call for contraception, but this is not complemented with training received by family medicine personnel.

As for the supply of external training to health centres, there is an increasing variety of specialised training courses on sexuality imparted by scientific associations and societies, associations of professionals, universities and research institutes.

In relation to training on methods to exercise decisive maternity and paternity specifically, the level of update is very unequal and basically depends on the care level in which the professionals find themselves. Some Communities hold occasional refresher courses but save for these exceptions there is no specific training offered by health administrations nor is this incorporated into the general courses imparted.

Aim for the training of professionals

1. Improve sexual health training of the group of professionals who work in the different health and social fields from a holistic approach based on rights and gender.

Recommendations

1. For lifelong training on sexual health, common criteria on quality, training content and educational methodologies in the different Autonomous Communities, taking the theoretical framework of Sexual Health as a reference, will be agreed.
2. Training will be strengthened for professionals with the purpose of getting them involved in promoting sexual health care considering the socioeconomic, cultural and gender determining factors in addition to different vulnerable situations in the different population groups from a sexual and reproductive rights approach.
3. The training of health professionals will be tackled from a gender perspective and will include the incorporation of sexual and reproductive health into curricular programmes of degrees related to medicine and health sciences, including research and training on the clinical practice of voluntary abortion (Organic Law 2/2010).
4. The training of health professionals will be tackled from a gender perspective and will include sexual and reproductive health in lifelong training programmes throughout a professional career (Organic Law 2/2010).
5. Maps of professional competencies (knowledge, skills and attitudes) for the different professional profiles with the purpose of incorporating sexual health aspects into care practice within the framework of this Strategy, will be prepared.

6. Gerder perspective training on early prevention and diagnosis of STI and HIV, will be stressed.
7. Training from a sexual diversity viewpoint, which considers the reality and needs related to sexual health for all persons, regardless of their sexual options and orientations and gender identities, will be stressed.
8. Means of communication and collaboration with the field of education to include sexual health from an integral and gender perspective in postgraduate and specialised university studies will be encouraged.

2.4.4. Research, innovation and good practices

Biomedical scientific research contributes to formulating new considerations and treatments to resolve some difficulties related to STI, the experience of sexuality and determined problems and concerns which may affect sexuality. The contributions to improve the efficacy and safety of contraceptive methods are also important in addition to the review about their possible side effects on health.

From the review of scientific and social research we detect limitations regarding integral studies on health, sexuality and sexual and reproductive rights from a bio-psychosocial perspective and integrated gender approach.

In addition, the generation of information on sexual health for scientific research has to guarantee its quality while at the same time avoiding conflicts of interest between the entities offering finance and the research teams.

According to the analysis performed for the diagnosis in general, health administrations from Autonomous Communities and Autonomous State Cities do not have financing for research and innovation in sexual health although in some communities studies on this topic have been promoted.

Regarding the collection of information and dissemination on good practices on sexual health care with a holistic and gender approach, these are still insufficient among the different care levels of each Autonomous Community and between the different Autonomous Communities and Autonomous State Cities. The NHS can promote care and promotion of sexual health from improvement of pre-existing services in addition to encouraging the creation of other new services which are suited to the needs of society. While for this purpose we need to have mechanisms to detect good practices which help to collect and systematise relevant and successful experiences which can be extrapolated to other contexts.

Currently, existing knowledge is incipient in areas such as sexual violence against women, young people, unwanted pregnancies and prevention of STI, food and sexual health disorders, joint responsibility and sexuality, gender identities, other forms of prevention such as microbicides and female condoms, which offer women different alternatives with which to exert more control over their sexual health, etc. Therefore, research and dissemination of good sexual health practices is important which will make it possible for the intervention of public health policies to gain efficacy and have a positive impact on the life of men and women.

Aims for research, innovation and good practices

1. Encourage the generation of knowledge which contributes to improving the quality of sexual health care from a holistic and gender approach.
2. Managing, compiling and disseminating existing knowledge on sexual health.

Recommendations

1. Quantitative and qualitative research on sexual health and their determining factors for the impact on health services, quality of services and efficacy of interventions, will be encouraged.
2. Research on the use, access and safety of methods to prevent STI and contraceptives considering sexual and reproductive rights, information processes, taking decisions and joint responsibility, will be promoted.
3. Bioethics studies which bring to light the effects of drugs on the health of men and women, with a special emphasis on sexual health, will be promoted.
4. The development of innovative research projects on sexual health care, which have a positive impact on the life of men and women, will be encouraged.
5. Studies to ascertain the needs, difficulties and problems of the sexual health of lesbians, gays, transsexuals and bisexuals will be promoted.
6. The communication and dissemination of good practices for the promotion of sexual health, prevention of its alterations and implantation of public policies and services will be encouraged.

7. Multidisciplinary workgroups to incorporate sexual health into protocols, guides, means of practice or any instrument to improve care practice and care of people with chronic diseases considering the framework of this Strategy, will be created.

3. Reproductive Health

3.1. Work methodology

The starting point of this National Strategy for Sexual and Reproductive Health (ENSSR), as for aspects of reproductive health, arises from the own process of preparation of the Strategy for Care during Normal Delivery (EAPN) within the National Health System (NHS) which has been developed and implemented for two years.

Since its creation in 2004, the Women's Health Observatory (OSM) has been dealing with aspects of equity of access and quality of care within the NHS and since then actions to improve the quality of care for the reproductive process have become especially relevant.

The work involved participation, listening to and meeting with women's associations, professional sectors and entities which presented specific requests on requirements for priority improvements for the quality of care offered to women and babies during the delivery and birth and then, to continue the work commenced with an integral consideration of the whole process, thereby also tackling pregnancy, the puerperium and the neonatal period from the same viewpoint of improving the quality of care and increasing the satisfaction of the user population.

Action was taken by means of organising two workshops. On one hand, social organisations and women's associations and on the other, experts and professional sectors involved which could exchange information, opinions, needs and proposals for improvement. The debates highlighted the increase in the last few years of excessive medicalisation and performing unnecessary routine clinical practices, currently ill-advised because of evidence from the World Health Organization (WHO) and existing good practices. To confirm this, an exhaustive review of the scientific evidence available was performed. The effort to reach a consensus between all parties to make the Strategy a reality is notable.

The result of the consensus was an initial document on care during childbirth, which was discussed and extended by professional sectors, social and women's organisations and autonomous administrations. At the meeting held in June 2007 attended by the Spanish Society of Gynaecology and Obstetrics (SEGO), the Federation of Associations of Midwives in Spain (FAME), the Spanish Association of Midwives and the Association *El Parto es Nuestro* [Birth is Ours] (EPEN), the results of the search for scientific evidence performed by

the Women's Health Observatory was facilitated and proceeded to make a comparison with the clinical practices performed in NHS hospitals. In July 2007, new contributions were made from the viewpoint of autonomous health administrations at the meeting held with people designated as representatives by Autonomous Communities.

In September 2007 a Conference for presentation of the EAPN in the NHS was held with broad attendance and participation of care professionals, health management, teaching and research in addition to representation from professional societies, social and women's organisations. The Conference included plenary sessions which were complemented with four simultaneous workshops corresponding to the four strategic lines of the document: clinical practices, participation of women, training professionals, and research, innovation and good practices. The four workshops were based on a common aim, to agree on a document from the situation analysis which offers recommendations to improve the quality of care based on scientific evidence to achieve the maximum number of alliances between professionals, civil society and administration of services.

Finally, the document was assumed at the highest institutional level with approval by the plenary of the Inter-territorial Council of the National Health System (CISNS) which was followed by constitution of the Institutional (IC) and Technical (TC) Committees for its implementation and follow-up.

Parallel to the preparation of the EAPN, the MSPS established lines of finance for perinatal and birth care health projects presented by Autonomous Administrations to implement the recommendations from the EAPN. On the other hand, it also offers institutional and financial support to the initiatives from the entities involved and aimed at disseminating and developing the recommendations of the EAPN.

Similarly, the MSPS is responsible for preparing technical instruments to accompany implementation of the EAPN, in accordance with the Quality Plan for the NHS:

- "Clinical Practice Guide for birth care", with the established GuiaSalud methodology is assigned to the Agency for Health Technologies Assessment of the País Vasco and the Agency for Health Technology Assessment of Galicia Avalia-t. Different professional sectors involved and users represented participated in its preparation.
- "Standards and recommendations for hospital birth care", which reports on the organisational and management aspects (including quality management and patient safety) in addition to those related to planning and design of hospital units dealing with deliveries.

Representatives from the scientific societies related to care at delivery and birth participated in its preparation.

The participation of entities involved throughout the process of consensus and preparation of documentation was recognised and made official in June 2008 with the formal constitution of the Committees responsible for follow-up of implementation and development of the Strategy:

- The IC comprised of people designated by all the Autonomous Communities and the National Institute for Health Management (INGESA in representation of Ceuta and Melilla), representatives from the related Ministry units (Public Health, Office for Health and Quality Planning, Institute of Health Information and Portfolio of Services) and the OSM which coordinated and leads this process.

- The TC, comprised of:

  Professional and Scientific Societies: Spanish Association of Midwives, FAME, SEGO, Spanish Neonatology Society, Initiative for Humanisation of Care during Birth and Breastfeeding (IHAN), Spanish Association for Primary Care Paediatrics, Maternal Breastfeeding Committee from the Spanish Association of Peadiatrics, Spanish Society of Perinatal Medicine, Association of Community Nursing, Spanish Society of Social Paediatrics, Spanish Society of Family and Community Medicine (SEMFYC) and Spanish Society of Anaesthesiology and Resuscitation.

  Social and women's organisations: Platform Pro Rights for Birth, EPEN, Vía Láctea, La Leche League, Spanish Interest Group for population, development and reproductive health (SIG), Centre for Gender Studies and Masculinities, Association *Prematura*, Women's Association for Health, Spanish Committee for Disabled Representatives (CERMI), Committee for Research on Abuse of Women (CIMTM), and experts.

At the meeting to set up the Committees there was agreement on the preparation of a document which serves as a basis for a new Strategy to tackle the entire reproductive process; therefore, it was agreed to set up three working groups on pregnancy, the neonatal period and puerperium, with a work schedule which, in addition to meetings to attend, considers working by means of an online tool (eRoom). There was also a debate on the state of implementation of the EAPN, which is combining efforts and managing to achieve the quality of birth care in Spain. Nonetheless, aspects arise which are necessary to improve such as training of professionals and setting up indicators and systems for registry and information.

Holding the working day to follow up the EAPN on 23 September 2008, open to professionals and interested social and women's organisations highlighted the interest and expectations on this topic. The participation of Alberta Bacci, Regional Coordinator of Making Pregnancy Safer, from the Regional European Office of the WHO and the communication of some national reference experiences (Hospital de Huércal Overa de Almería, Hospital La Plana de Castellón, Hospital de Santa Caterina de Gerona) served to exchange information and disseminate good practices which could be debated in subsequent workshops organised on: 1.-*Innovation and Good practices, 2.-Legal Aspects*; 3.-*Structural and Architectonic Aspects; 4.-Instruments for Quality in Care*, whose conclusions have guided the development of the EAPN.

Coinciding with the working day, a meeting was held with the IC to follow up the projects corresponding to lines of financing agreed and there was debate on the priority aspects to drive forward the Strategy. As fundamental aspects to be tackled, the need to share quality indicators and set up a compatible system to record the information and train professionals are notable. Therefore, two work groups were created to be responsible for development of both aspects; a period for inscription of participants from the Technical and Institutional Committee was set up.

The Working Group on Indicators performed its task by means of networking and in the meeting of 10 December 2008 at the MSPS agreed on a list of 15 basic indicators which had to be collected in Spanish public hospitals and a questionnaire on good practices and/or qualitative indicators, whose information will be supplied by representatives from each Autonomous Community and INGESA in the IC. Both documents comprise the quality assessment tool for care during delivery and birth, characteristics similar to that promoted by the WHO, which enables self assessment of each centre or the practices of each Autonomous Community. A starting point is considered to be continuing work to achieve effective action which enables performing the planned assessment of the EAPN within the NHS.

The Training Working Group, at the meeting of 10 February 2009 in the MSPS, agreed a training programme split into two sections: an Intensive Seminar (focusing on all the top priority aspects); and monographic workshops (enabling going further into depth on the principal topics). Both training activities are aimed at training of trainers. The National Committee for Lifelong Training recognised the teaching assigning 7.8 and 2.4 credits respectively.

The Intensive Seminar held on 21-23 April 2009 was a gathering of midwives, obstetricians and paediatricians from all Autonomous Communities, Ceuta and Melilla with the aim of sharing the same technical content and

setting up multidisciplinary teams in each area which would enable extending training in the respective fields and also comprising a network of professionals capable of imparting training. Because of its nature of training of trainers, it had the support materials and necessary technological instruments to be able to easily reproduce this content in the different areas. Autonomous Communities have designated professionals and facilitated their attendance by financing the corresponding travel expenses. In addition to training activity to attend, the student body performed subsequent practical work consisting of planning and executing a training project in each area.

The first workshop was held on 23 September in the MSPS. Its organisation and methodology was similar to that considered in the seminar. The aim consisted of going into depth on priority aspects and jointly ascertaining and debating the existing good practices on the topics selected. The student body also made an undertaking to perform a practical activity: extend training acquired in the workshop to activities to perform in the respective areas.

The IC and IT meeting of 16 March 2009 dealt with the state of development of the EAPN in general terms and agreed upon the suitability of implanting the basic indicators agreed and setting up common registry systems which enable obtaining the information; the state of grants aimed at perinatal health projects and the specific health projects to improve the quality and warmth of care during a normal delivery were also set out. For both grants the criteria proposed for the priority lines to finance and to prepare the respective activity reports were also debated.

Two working groups were set up during 2009. One of these was responsible for preparing and agreeing a delivery and birth plan which serves as a reference for the entire NHS. As a starting point, work was performed on review of existing delivery plans to date in the different Autonomous Communities and is currently in preparation. The other work group will be responsible for preparing the plan to disseminate and implement the Strategy.

The IC and IT activity in the past year has focused on shaping the document which was the basis for this Strategy. At the meeting held on 29 June 2009, there was broad debate on the initial draft, opinions were exchanged and the contributions of each person comprising the TC and IC were reported. At the meeting held on 5 October 2009 a review of all the document's points was performed; following the debate, new suggestions were made. A period was agreed to send new contributions and obtain the final draft as a result.

The participatory methodology used during the process therefore turned into an added value and legitimised the policy approved as we commence with the request and participation of the receiving citizens, the involvement

of related professional sectors and the undertaking by State and autonomous health administrations to improve the quality of care during the reproductive process.

3.2. Reproductive health in Spain

As of the second half of the 20th century there was a slow process of change in care during delivery as women and families demanded more humanisation of childbirth. During the 1960s and based on theories on emotional bonding, a movement arose in the West which sought to alter hospital procedures.

Mother-child care focused on the family was developed during the second half of the 20th century in the USA and Canada. This arose when society and specifically, mothers and fathers, started to question the need for rigid procedures of hospitals which tended to separate the couple during the delivery and birth work and after this, separate the mother from the baby.

At the meeting of experts for multidisciplinary care during childbirth which took place in Fortaleza (Brazil) in 1985 a series of proposals covered in the so-called Declaration of Fortaleza were prepared. These recommendations from the WHO, reinforce the concept that pregnancy and childbirth are physiological processes; for this reason it is aimed for the care provided to be coherent with this definition, that is, that the suitable technology be used for each delivery and childbirth process, and recognise the important role of the woman herself in taking decisions which affect her.

Families resort to the health system because they wish to have their children under the safest conditions. Couples seek help from professionals and wish to experience this process as a unique, special and highly meaningful experience.

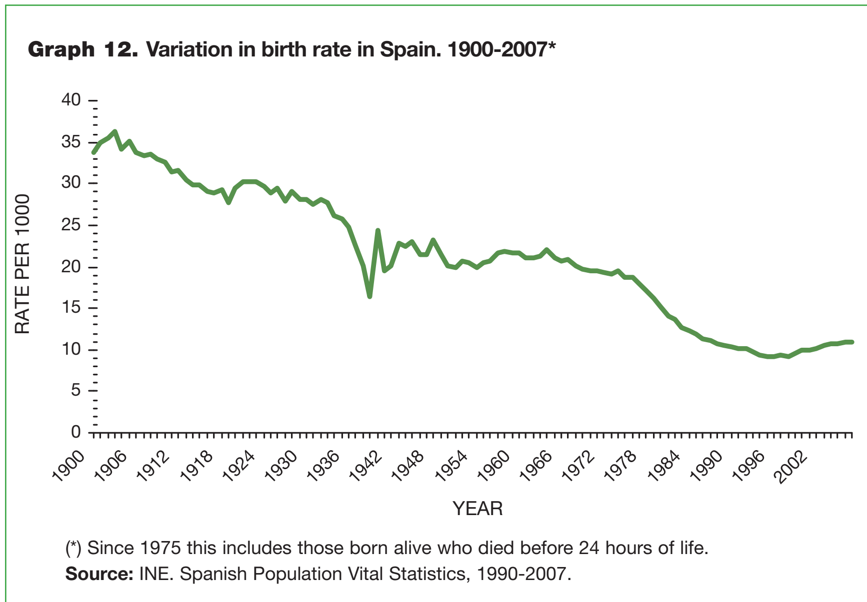
The NHS planned to develop the EAPN in response to a collective demand to improve care during delivery and childbirth, taking into consideration the emotional aspects this process entails and the participation and protagonism of women during this process. This document was approved during the NHS Inter-territorial Council Plenary in October 2007 and gathered everyone, including professionals and groups involved, so that they could debate, agree, prepare and bring into practice the necessary aims and actions.

As of the enacting of General Health Law 14/1986, of 25 April, Spain has been characterised by a public health system with an extensive portfolio of services, some optimal health indicators and universal and balanced health coverage.

At the moment, we are facing the challenge of orienting health care to a clinical practice based on scientific evidence and focused on the user, basic criteria to implement new strategies which guarantee care services in accordance with the NHS Quality Plan.

In Spain, we have observed a decline in the birth rate since the start of the transition to democracy because of a higher number of women working, their ability to earn income and a higher education level, together with the legalisation of contraceptive methods in 1978.

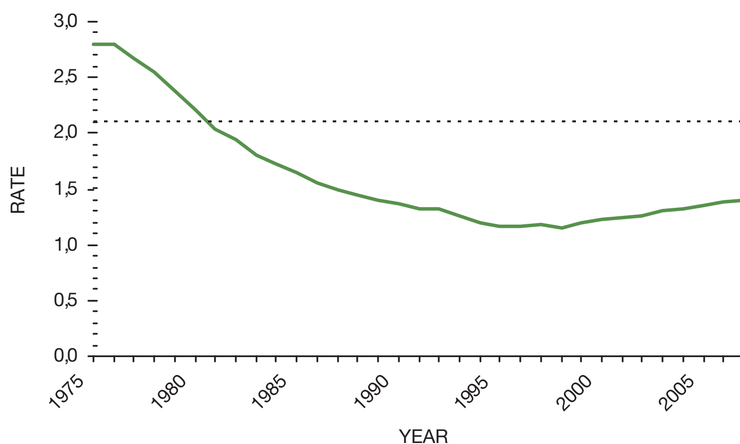
Graph 12. Variation in birth rate in Spain. 1900-2007*



(*) Since 1975 this includes those born alive who died before 24 hours of life.
Source: INE. Spanish Population Vital Statistics, 1990-2007.

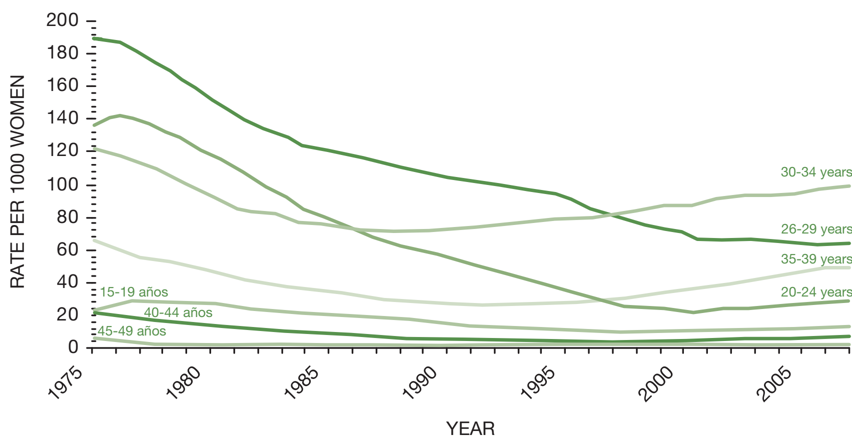
Since the 1980s the total fertility rate has declined until the end of the 1990s when it stabilised. This is 1.5 below the replacement rate. This replacement rate (2.1 children per woman) significantly affects the makeup of the population as the demographic change is associated with economic and social effects related mainly to the ageing of society and decline of the active population.

Graph 13. **Total fertility rate[9] (or synthetic fertility index). Spain, 1975-2007**



Source: INE. Spanish Population Vital Statistics, 1975-2007

Graph 14. **Age-specific fertility rate[10]. Spain, 1975-2007**

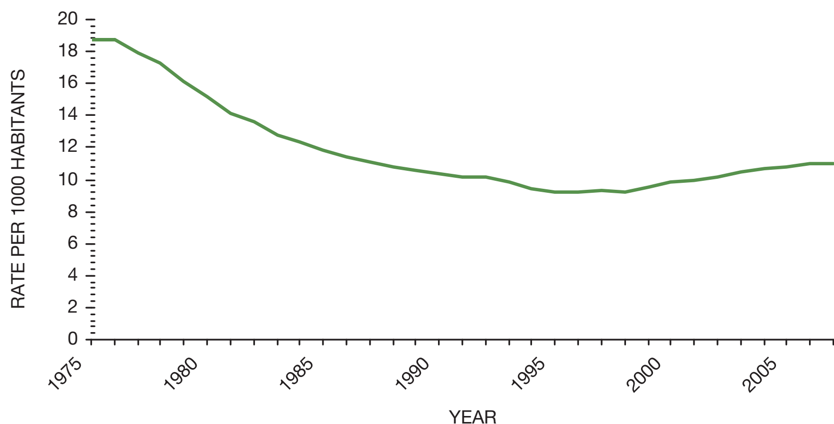


Source: INE. Spanish Population Vital Statistics, 1975-2007

[9] The number of children a woman could give birth to over her life if she lives her fertile years in accordance with fertility rates for age in a determined year. This rate is therefore completed fertility for a hypothetical generation computed by the sum of fertility rates by year of a woman in a determined year (supposing the number of women of each age are equal). The total fertility rate is also used to indicate the replacement of the level of fertility; in most developed countries this is a ratio of 2.1

[10] Fertility rate by age=children born to women of a determined age x 1000/women of this age

Graph 15. Gross birth rate per 1000 inhabitants. Spain, 1975-2007



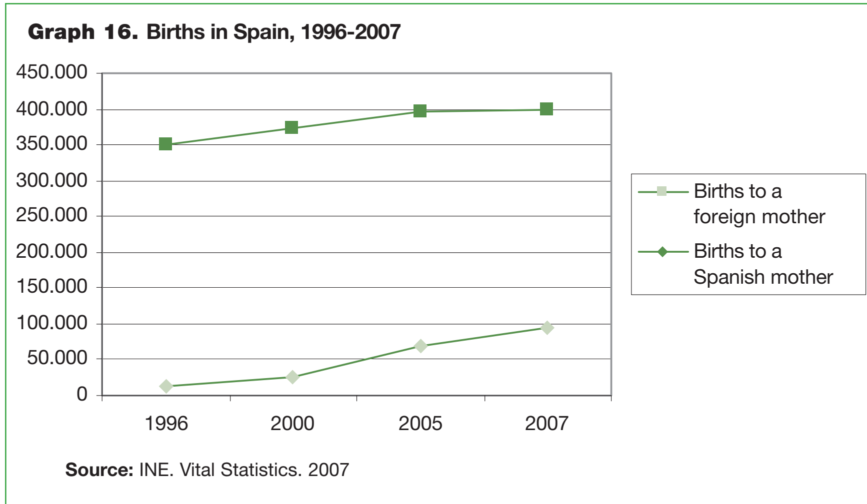
Source: INE. Spanish Population Vital Statistics, 1975-2007

According to the latest data available, the number of births in Spain increased from 466,371 in 2005 to 492,527 in 2007, which is an increase of 5.6%. The number of births to a foreign mother underwent a higher increase; in 2005 this was 70,259 and attained the figure of 93,486 in 2007, representing an increase of 33%, while those born to a Spanish mother have stabilised since 2005.

Table 3. Number of births by Autonomous Community and sex of the newborn. 2005, 2007

	2007			2005		
	Both sexes	Men	Women	Both sexes	Men	Women
Total	492.527	253.895	238.632	466.371	240.201	226.170
Andalucía	96.062	49.486	46.576	91.807	47.230	44.577
Aragón	12.859	6.615	6.244	11.628	6.024	5.604
Asturias (Principado de)	7.833	4.032	3.801	7.482	3.849	3.633
Balears (Illes)	11.917	6.147	5.770	10.925	5.719	5.206
Canarias	19.740	10.207	9.533	20.127	10.390	9.737
Cantabria	5.379	2.748	2.631	5.267	2.682	2.585
Castilla y León	20.077	10.459	9.618	19.425	10.043	9.382
Castilla-La Mancha	20.875	10.684	10.191	19.007	9.829	9.178
Cataluña	84.037	43.292	40.745	79.766	41.331	38.435
Comunitat Valenciana	54.478	28.120	26.358	50.628	26.091	24.537
Extremadura	9.981	5.189	4.792	9.993	5.130	4.863
Galicia	21.752	11.216	10.536	21.097	10.867	10.230
Madrid (Comunidad de)	74.837	38.489	36.348	69.367	35.407	33.960
Murcia (Región de)	18.602	9.582	9.020	17.330	9.004	8.326
Navarra (Comunidad foral de)	6.595	3.420	3.175	6.149	3.099	3.050
País Vasco	20.594	10.625	9.969	19.698	10.102	9.596
Rioja (La)	3.272	1.696	1.576	3.038	1.543	1.495
Ceuta	1.136	576	560	1.065	543	522
Melilla	1.112	580	532	1.012	504	508

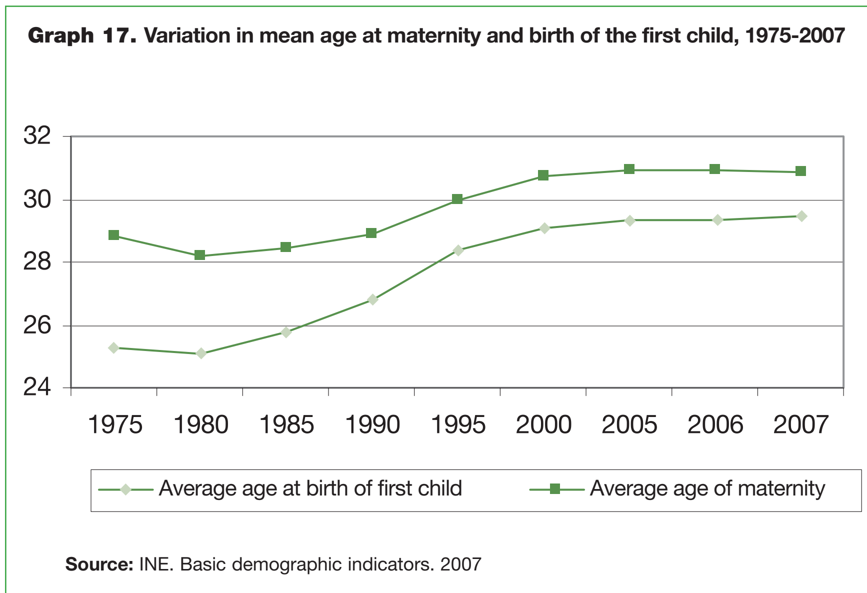
Source: INE. Vital Statistics. 2005, 2007



Graph 16. Births in Spain, 1996-2007

Source: INE. Vital Statistics. 2007

The mean age of women who give birth regardless of whether or not it is their first child increased during the 1980s and 1990s, but this stabilised at approximately 31 years this century. As for the first birth, the mean age of women has also followed a similar pattern although with somewhat lower figures; in 2007 this was 29.43 years.



Graph 17. Variation in mean age at maternity and birth of the first child, 1975-2007

Source: INE. Basic demographic indicators. 2007

Care during pregnancy

According to a study[12] requested by the Women's Health Observatory, almost 50% of health centres perform some kind of action to include pregnant women in their programmes to follow up the pregnancy process. The most frequently used activity in all Autonomous Communities is giving information in the consultation when communicating confirmation of the pregnancy to the woman. Other actions which are less frequently used are information by means of posters, leaflets, explanatory videos or chats. The least frequently used strategy is making an appointment from the health centre.

The majority of health personnel mainly inform women during prenatal guidance programmes of the importance of early skin to skin contact and placing the baby on the mother's chest during the first few minutes following the birth. They also provide updated information on clinical practices and rights of women to participate in taking decisions on non-pharmacological alternatives to relieve pain, mobility and different positions during the delivery, on the benefits of having a person accompany the woman, and being able to prepare a plan for childbirth and delivery.

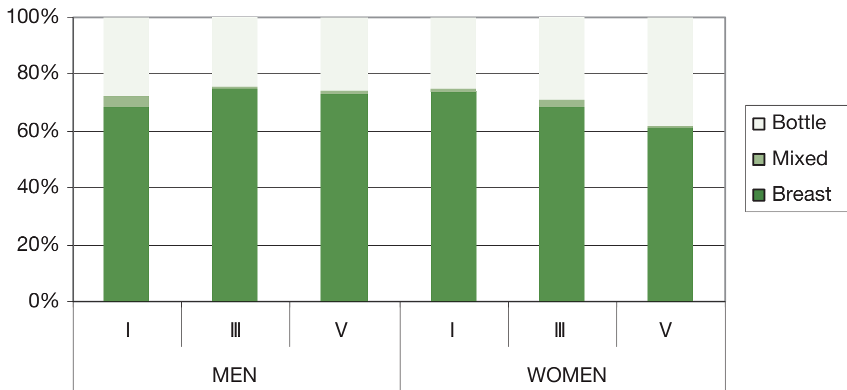
Maternal breastfeeding

According to the National Health Survey (NHS; 2006), the prevalence of children fed by maternal breastfeeding during the first six weeks (obligatory period for maternity leave) attains 68.4%.

If the woman is the main breadwinner, this has an influence on practicing maternal breastfeeding according to social class; unqualified workers are those who practice this least. This situation reverses when the baby is 6 months old and it is women breadwinners from the highest social class who report a lower percentage of maternal breastfeeding.

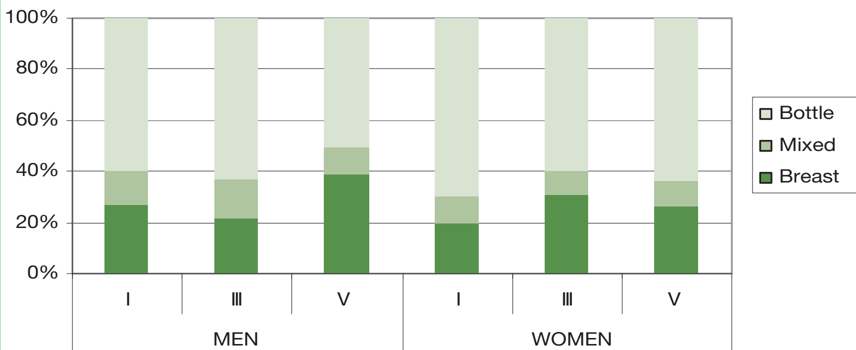
[12] Care during pregnancy, birth and puerperium in Spain. Andalusian School of Public Health. 2007

Graph 18. Percentage of breastfeeding according to sex and social class of the main breadwinner at 6 weeks. 2006



Source: INE. National Health Survey. 2006

Graph 19. Percentage of breastfeeding according to sex and social class of the main breadwinner at 6 months. 2006



Source: National Health Survey. 2006

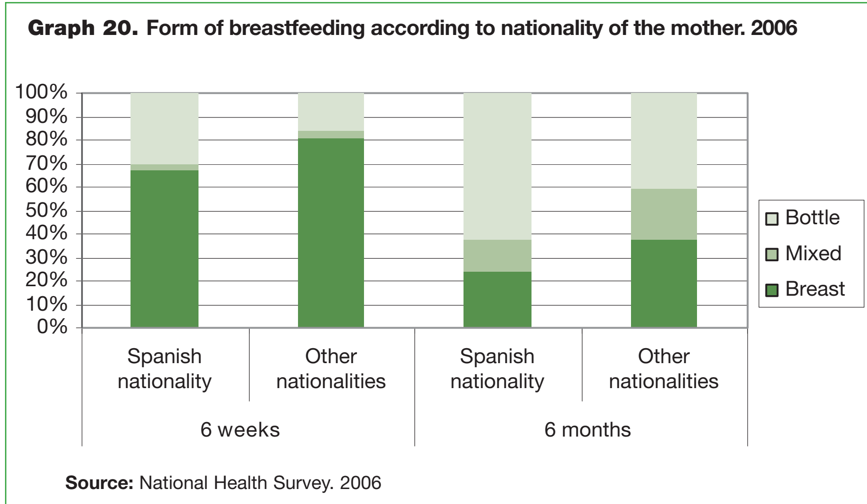
I: Management of Public administration and companies with 10 or more employees and professions associated with advanced qualifications

III: Administrative job and administrative and financial management support professionals. Job in personnel personal and security. Freelance work. Supervision of manual jobs

V: Unqualified work

According to nationality, maternal breastfeeding is selected and maintained at 6 months to a greater degree by women of another nationality.

Graph 20. **Form of breastfeeding according to nationality of the mother. 2006**



Source: National Health Survey. 2006

Care during the puerperium

According to the study cited, approximately 44.8% of health centres (of a total of 484 centres) perform two puerperium visits and 4.3% more than three. No variability is observed regarding the time of the first visit given that the majority of centres perform this during the first week post-delivery.

Of the health centres, 47.2% offer some kind of guidance following delivery. The most frequent initiative (89.9% of centres which carry out some) are chats or workshops with mothers and breastfeeding support groups. Other kinds of initiatives are also carried out to a lesser extent such as information during the puerperium visit (4.3%), information in leaflets, DVD or audiovisual material (5%), inclusion in child health programmes (from 0 to 3 years) with midwives and paediatricians (0.7%), or chats together with paediatricians or social workers (0.7%).

Of the health centres, 23.4% state that they perform initiatives to encourage joint responsibility of parents during child rearing. The majority of centres indicate they do this via mothers (they are advised to take their partners with them or they are reminded in the consultations). At times, they make specific invitations and/or adapt the activity to the availability of mothers and fathers.

Perinatal care

Recently, care during pregnancy, childbirth, the puerperium and neonatal period in Spain has undergone a change with the strenghtening of Primary Care (PC) and bringing health services closer to citizens which has meant that Autonomous Communities have been introducing changes into care based on clinical protocols, regulations and projects on an institutional level to favour the demedicalisation of the process. In addition, with the development and implementation of the EAPN, Autonomous Communities have made progress in making the care model [scientific] evidence-based to achieve a more humanised process.

Traditionally, care during pregnancy has been performed in obstetrics consultations and by medical personnel but currently this care model has changed; midwives, or midwives sharing the work with gynaecology personnel, deal with pregnancy in many health systems. The adoption of one model over another depends on the human resources available and the health infrastructure and organisation of each Autonomous Community but basically the common aim is to simplify and demedicalise the follow up of pregnancy. Therefore, it is decisive to correctly identify the women who may benefit from more suitable control and avoid those tests whose application is not advised for the healthy population.

In general, care during pregnancy and puerperium in specific sexual and reproductive health care units in PC facilitates access of women to the service and guarantees equality; to achieve this, it is necessary to combine criteria of scientific evidence, subsidiarity and cost-benefit given the significant variability in care existing today. In the case of care during the puerperium and neonatal period, some centres opt for a longer hospital stay. Others, however, have implemented an early discharge system facilitating access of women to PC consultation by midwives, paediatrics and nursing for follow up from the outset which enables preventing problems and/or detecting and treating them in time. Just as for care during pregnancy, the availability of resources is important. There are centres which cannot offer domiciliary care during the first few days. However, others have a domiciliary support network with midwives.

Most hospital maternity departments have removed the bassinet system given the evidence of the damage caused to the baby, woman and family by this model. One further step is the gradual adoption being performed by the country's obstetrics departments of immediate mother-baby skin to skin contact following normal deliveries and many pathological deliveries given the benefits this provides.

Finally, we highlight that since the implantation of the EAPN, care during normal delivery has undergone significant changes in most Autonomous Communities; all of these have made efforts to improve the warmth and quality of care and the good practices being developed are gradually more numerous.

3.3. Strategic aims and lines for reproductive health

General aim

To offer overall, continued, integral and quality care during the reproductive process within the National Health System, based on the best available knowledge focused on the needs and circumstances of users and aimed at promoting a human, intimate and satisfactory experience for women, their partners, babies and family.

Specific aims

1. To promote the health, well being and autonomy of pregnant women. Correctly facilitate their involvement in the physiological process and their care and provide care adapted to the needs and circumstances of each woman and partner.
2. Enhance care during normal delivery. Improve the quality and warmth of care by favouring a climate of trust, security and intimacy of women and ensure they are supported and respected by professionals with current safety levels upheld.
3. Improve conditions for the birth. Guide care to the baby's well-being, their appropriate adaptation to extrauterine life, the establishment of the emotional bond, maternal breast feeding and care centred on development and families.
4. Promote the health and well being of women during the puerperium. Continue care by providing advice and care, exploring their needs, emotional and psychological changes and state of the bond, breastfeeding and support of the partner.
5. Potentiate the aspects that should be considered transversely throughout the process. Stress the importance of training professionals, the

participation of women and their partners (considering multicultural aspects and disability), institutional coordination and research and dissemination of good practices.

6. Potentiate a change in social values on maternity and paternity traditionally specified in unattainable demands for mothers and tolerance of a low involvement by fathers.

Strategic lines:

Care during pregnancy

The fundaments of prenatal monitoring have changed to a large extent in the last few years in addition to the intensity of the care proposed and also our knowledge on its capability to have an influence on maternal and perinatal health. Care for pregnant women differs significantly from other medical procedures as this is aimed at the healthy population during a significant and important physiological process in the life of women, their partners, babies and families. Therefore, respect for the natural evolution of the pregnancy should be the focus of all healthcare and any intervention should be assessed to be applied only if it is revealed to have a benefit and in accordance with the needs and desires of each woman. This involves offering top quality, scientific, personalised care which considers the identification of psychosocial risks and specific needs, which contributes to making women capable of taking informed decisions, improving their knowledge of the process and providing maternal and paternal preparation by offering continued support by expert professionals. There is considerable evidence on prenatal care that enables preparing recommendations and identifying those matters that require new investigations.

There is also evidence (based on investigations, clinical trials and good practices) to avoid performing a series of clinical tests and practices which have proven to be ineffective and even damaging for the physical and psychological health of mothers and children.

3.3.1. Promotion of health in pregnancy

Aims:

To promote the health, well-being and healthy lifestyles for women and their families from the onset of pregnancy by providing quality information on the process and supporting the development of attitudes and skills necessary to improve habits and considering the individual needs and circumstances of each woman.

To develop a relationship of trust and empathy with the pregnant woman exploring her ideas, concerns and expectations and ensuring she understands the advice or guidelines provided and assessing the undertaking made by her partner.

Recommendations:

1. Ascertain the **state of health** of each woman, her physical and psychological reaction to stress factors, the basic characteristics of her personality and history, personalise her requests and choices and ascertain the emotional disposition of the woman towards pregnancy and the changes that maternity entails.
2. Offer **continuous quality care to maternity**, which looks after the human relationship, the dissemination of correct information, empathy, the development of resources for the woman to face stress related to the pregnancy and empowering the woman throughout the whole process. Avoid information which generates stress and anxiety based on the description of pathologies which do not exist in her specific case.
3. Recommend a balanced **diet** and dental hygiene habits. Stress the importance during pregnancy and make women aware about the beneficial effects for them and their babies. Inform about the precautions to reduce risks of acquiring infections transmitted by food.
4. Identify possible risks related to **productive or remunerated and reproductive or domestic work.** Inform women about the adoption of suitable measures, their rights and existing labour regulations for the protection of maternity (gestation, postpartum and breastfeeding). Advise paying attention to their need for rest and leisure time.
5. Inform about different ways to **express or enjoy sexuality** adapted to the new needs during the different phases of gestation from a broad

and diverse perspective of expressing sexuality and explaining the usual anatomical changes.

6. Inform about measures to prevent **sexually transmitted infections** (STI) both to the women and the partner.

7. Inform about the risks of consumption of **alcohol, tobacco and other addictive substances** during pregnancy. If a pregnant woman is a smoker, inform about the harmful effects of smoking to her health and her baby's health and use this moment of special sensitivity to offer health advice and support to stop smoking and avoid making the woman feel guilty. Inform women who suffer from passive smoking of its harmful effects and facilitate strategies to tackle the problem.

8. Regarding taking **medications**, inform that they should only be used in those cases where the benefit exceeds the risks. Advise against using any kind of medication or therapy without a prescription and monitoring by health professionals.

9. Encourage **physical activity** and practice moderate exercise. Advise physical exercise in water given that this also seems to have positive benefits on the discomfort inherent to pregnancy (lower back pain, heavy legs, etc) and relaxing effects. Recommend exercises which favour blood circulation. Advise against risky, energetic or high-impact sports.

10. Facilitate recommendations to pregnant women who are to undertake **international** trips. Inform about the correct use of safety belts in the car and other means of transport.

11. Promote the **psychological and emotional well-being** of pregnant women by providing suitable information to women and their partners on the emotional and psychological changes which are habitual during gestation. Professionals who care for healthy pregnant women should recall:

- The importance of developing a relationship of trust and empathy with pregnant women by exploring their ideas, concerns and expectations.

- Carry out an appropriate anamnesis which detects psychosocial risk factors, assessing the relationship of the women with their surrounding family and the degree of support they receive.

- Ensure that there is a normal phenomenon during gestation defined as psychic transparency by which experiences and recollections of

childhood and the maternal relationship can develop as a healthy and necessary adjustment.

- Avoid stress factors arising from performing any unnecessary examination or alarmist information as it has been proven that maternal anxiety may be damaging for the baby in development.
- Effective companionship by their partner or person the future mother trusts throughout the process facilitates the emotional well-being of the woman and has preventive effects.

12. Implement the necessary measures to **detect and tackle violence and sexual abuse**, following health protocols for these cases.
13. Ensure that the **surrounding family** of pregnant women take responsibility to improve healthy habits and facilitate their necessary rest.
14. Integrate the promotion, education and support for **maternal breastfeeding** in prenatal education consultations by respecting the personal, social, work-related, contextual and cultural circumstances of each woman.
15. Comply with the **Trade Code for Breast Milk Substitutes**, avoiding practices such as delivering briefcases with industry gifts or teats, dummies or samples of substitutes and accepting covert advertising by means of the use, in consultation or institutions, of stationery material with advertising.
16. Improve the **coordination** between prenatal consultations, hospital maternity departments, PC centres and maternal breastfeeding support groups (BF) in the community with the purpose of providing homogeneous information to pregnant women and their surrounding family.
17. Prepare **information and educational materials** to promote health during pregnancy which may be used in the entire NHS and which are based on the best existing knowledge.

3.3.2. Health care during pregnancy

Quality health care for pregnant women entails efficient follow up of the process, performing visits, tests and procedures based on scientific evidence, the involvement of users and suitable coordination of primary and specialised care.

3.3.2.1. Information and procedures

Inform and identify in advance women with risk factors, health problems, complications of pregnancy or foetal anomalies with the purpose of minimising their consequences, facilitating additional prenatal care to women who require this and avoid medicalising the process in healthy women.

Information and procedures

Aim:

Provide information about the normal changes in the different stages of pregnancy, promote proper care and explain performing procedures, test and examinations.

Recommendations:

1. Obtain data from the **clinical history** in an appropriate setting and dedicate sufficient time assessing the state of health of women and life habits and family, personal and work-related risk factors from a bio-psychosocial viewpoint and with a gender approach.
2. Set up **suitable communication** which facilitates conversing on nutrition, supplements, the importance of maternal breastfeeding in feeding and raising the newborn, taking of drugs, consumption of addictive substances, exposure to toxic substances, etc. Hand women **printed material** with accessible and updated explanatory content.
3. Identify the women who require **additional care** for specific follow up of the pregnancy.
4. Calculate the Body Mass Index (BMI = weight in kg/ height in m^2) at the first visit to identify the women who require **dietary advice** and information on weight gain during the pregnancy. Weigh women individually in such a way that the monitoring of weight is always carried out as long as it provides benefits and avoids producing anxiety.
5. Measure the **blood pressure** at all prenatal visits with a correct technique (suitably sized cuff, the woman in a vertical position and after the arm has been at the level of the heart for 5 minutes).
6. Indicate blood analysis, detection of asymptomatic bacteriuria, prenatal diagnostic tests and ultrasound, with the **appropriate information**.

7. Determine a prenatal **appointments schedule** based on risk of each gestation and inform the woman verbally and in writing of the content of each visit. Where possible, try and ensure that visits and tests coincide (analysis, ultrasound, etc.).

8. Perform a **suitable number of visits,** between 4 and 8, throughout normal gestation, more for nulliparous then multiparous women. Visits in which the normal evolution of pregnancy is explained and in which the woman can express her doubts, insecurities and concerns, helps the woman feel secure, make decisions and attain a good experience of the process.

9. Structure each **prenatal appointment with some clear aims**. The first should be the longest to enable a full assessment of the risk of pregnancy, the needs of each woman and a broad discussion of all relevant issues.

10. Pay **attention to any indication, sign or symptom of physical, psychological and/or sexual violence**, given that the pregnancy places women at risk in a more vulnerable situation, such that maltreatment and abuse may commence or increase. This may also be the time to ascertain past abuse as this background may alter the normal evolution of the pregnancy, birth and puerperium.

11. All pregnant women should receive sufficient and updated information on the importance of **breastfeeding** and risks of not breastfeeding, in addition to training on favouring commencing and establishing breastfeeding following the birth.

12. During gestation sufficient and updated information should be offered on the available methods for **relieving and treating pain** during the birth. Information will be given on non-pharmacological methods (companionship, movement, massages, transcutaneous electrical nerve stimulation TENS, subcutaneous sterile water injections, use of immersion in hot water, etc.), on the pharmacological methods (intravenous remifentanil, self-administered nitrous oxide, intramuscular or intravenous petidine with or without haloperidol) and on epidural analgesia. It will be explained that the aim of analgesia during the delivery will not be full analgesia, but rather sufficient relief so that this is treated individually according to the free choice of each woman. Regarding epidural analgesia the woman should know that this is the method which provides the most effective analgesia during the delivery and, in case the birth is a caesarean delivery, this enables the woman to be awake. This involves

offering integral treatment of pain which means not only helping to relieve pain but also avoiding invasive or uncomfortable practices which are unnecessary, and creating a favourable setting for the delivery and looking after the wellbeing of women. Currently, a broad range of techniques can be offered and some of these can be used in a sequential and complementary way. **It is appropriate to hand in** at the consultation **written, in addition to verbal information,** on all the above and clearly explain the advantages and disadvantages of each method.

The following is not recommended:

- With the purposes of identifying difficulties for breastfeeding, performing a breast examination on healthy and asymptomatic women is not recommended. The treatments proposed for flat or inverted nipples have proven to be ineffective and counterproductive. Trying to anticipate whether problems will arise during breastfeeding leads to loss of confidence over possibilities to breastfeed.
- Performing a routine gynaecological examination during gestation. They are not indicated for all asymptomatic women to rule out infections, pathology, the condition of the cervix or cephalopelvic disproportion. However, **as an exception**, is recommended offering vaginal examinations to women who have undergone **genital mutilation** or those in whom this is suspected is recommended to assess the treatment they require during the delivery.
- Performing Hamilton's manoeuvre in healthy women with no indication of completion of gestation.
- Routine auscultation of the foetal heartbeat because it is of no predictive value and because it generates anxiety if this is not located quickly during the first few months of gestation. It is appropriate to perform this when requested by women.
- Cardiotocographic monitoring of the foetal heartbeat before 40 weeks during normal gestation.
- Performing cervicovaginal cytology for all women during the prenatal visit.

Preparation for the pregnancy, delivery, birth and childrearing

Aims:

Agree on a programme to prepare for the pregnancy, delivery, childbirth and child-rearing which facilitates a satisfactory experience, eliminating concerns and uncertainties and providing appropriate information on the entire process.

Meet the expectations and circumstances of each woman and partner and promote the personal autonomy and development of the pregnant woman (empowering) with the support of the partner. Encourage the emotional bond.

Recommendations:

1. Consider the needs of women and partners who attend group education by deciding the content, aims, methodology, schedule of sessions, audiovisual resources and necessary materials in addition to the assessment of satisfaction and results.
2. The preparation should cover both the process of maternity and paternity and deal with pregnancy, delivery, puerperium and care of the newborn.
3. Define the specific quality criteria and content and design a methodology and assessment for the training.
4. Involve the partners in programmes and consultations from the onset of pregnancy, dealing with their own needs and experiences.

Preparation of the Plan for Delivery and Childbirth

Aim:

Collect in a document the desires of each woman regarding pregnancy and childbirth following information and advice from the midwife responsible for her care.

Recommendations:

1. Perform, as long as the woman requires, a Plan for Delivery and Childbirth, ideally between weeks 28 and 32 of the pregnancy to deliver

this to the hospital of reference or the one chosen for the delivery. The plan will be received by the hospital and incorporated into the clinical history.

2. The midwife responsible for following up the pregnancy should inform, advise and help the woman to prepare the Plan.
3. In case some aspect covered in the Plan cannot be care for, the centre will duly explain the reasons which justify this. Before the delivery, the midwife responsible for the care will review and comment the aspects covered in the Plan with the woman.
4. The hospital will establish information systems which enable performing an assessment of the quality of the care for these Plans.

Ultrasounds

Aim:

Assess foetal vitality and gestational age, detect early multiple pregnancies and foetal malformations, classify chorionicity in the case of twin gestation and measure nuchal translucency.

Recommendations:

1. Explain to women and companions in an empathic way the benefits and limitations of obstetric ultrasound.
2. Offer pregnant women a high-quality ultrasound to screen for congenital structural anomalies in the first quarter (weeks 11 to 13+6 of gestation).
3. Offer an ultrasound approximately at week 20 to screen for structural abnormalities and inform that the 3-D ultrasound does not show an advantage over conventional 2D ultrasound.
4. There is no evidence which supports performing routine ultrasound in the third quarter as this has not been proven to have any benefit. If there is suspicion of the presence of a foetus with restricted intrauterine growth or there is another indication, inform the woman and offer the possibility of performing an ultrasound.
5. Take care with verbal and non-verbal communication at the beginning and during ultrasound examination to reduce the anxiety of the

woman and her partner who may interpret any gesture or word as an indication of pathology. Explain that what is normal is for the baby to be healthy and offer information during the test and/or at the end of the test in clear and comprehensible language.

Handling of gestation where there is breech position at term

Aim:

Increase the possibilities of vaginal delivery for women with foetuses presenting in breech position at term.

Recommendations:

1. Offer the external cephalic version (ECV) to pregnant women whose foetuses when reaching term are in breech position (a situation which occurs in 3% to 4% of cases), a procedure which entails, by means of foetal handling via the maternal abdominal wall, rotating the foetus from presenting its buttocks to a cephalic position. Request the woman's written consent with appropriate information on the procedure.
2. Inform women with a pregnancy with a foetus in breech position that:
   - ECV reduces the probability of a breech presentation during the delivery and during a possible caesarean delivery.
   - The probability of success of ECV is approximately 50%.
   - Delivery in a cephalic position following a successful ECV is associated with a higher proportion of obstetric interventions than in "spontaneous" cephalic presentations.
   - ECV should preferably be performed during week 36 for nulliparous women and week 37 for multiparous women. ECV is also possible after week 37.
   - There are few absolute contraindications, the rate of complications is very low and may be painful for which reason following appropriate information and signed consent, the woman will be offered the possibility of opting to use analgesia at the beginning or discontinuing the procedure to apply analgesic if they experience pain.

- Inform women about the possibility of using the moxibustion technique to modify the foetal position from breech to cephalic and its possibilities of success in accordance with the existing scientific evidence.
- Offer the possibility of vaginal birth in breech position in case ECV or other techniques do not succeed, especially for women who have had a prior vaginal delivery and comply with the requirements after receiving the appropriate information.

Care for women with a prior caesarean

Aim:

Offer a vaginal delivery to women with prior caesarean delivery and low transversal incision.

Recommendations:

1. Permit spontaneous vaginal birth startup when there has been a prior caesarean delivery, indicating that as long as there are no absolute contraindications the vaginal birth can be favoured. In case of not guaranteeing the level of care necessary, the pregnant woman with a prior caesarean delivery should be referred to the closest hospital maternity department which has the required facilities.
2. In case it is considered necessary to programme a caesarean delivery for other reasons, this should never be performed prior to 39 weeks of completed gestation unless there is an emergency or maternal or foetal pathology which requires this, with the aim of avoiding risks to the baby. Ideally, wait for the delivery work to commence.

Guidelines to low risk gestation between 41 and 42 weeks

Aim:

Offer special care to the pregnancy between weeks 41 and 42 weeks of gestation, with the purpose of preventing the mild but gradual increase in foetal morbimortality from this gestational age.

Recommendations:

1. Appropriately estimate gestational age by means of ultrasound during the first quarter without basing this only on the date of the last menstrual period which tends to overestimate this, leading to a higher number of interventions because of prolonged pregnancy.
2. Inform pregnant women that in 5% to 10% of cases the pregnancy is prolonged beyond 42 weeks. Explain that as of 40 weeks the risks to the foetus and likelihood of caesarean delivery start to increase very gradually. Evidence does not enable categorically indicating the need to induce the delivery as of a certain date because this does not reduce some of the risks and may increase others.
3. Offer the pregnant woman as of week 41+0 gestation the possibility of waiting for spontaneous onset of the delivery or induce delivery throughout week 41 with the best available method and appropriate information.
4. When the woman refuses induction as of week 41, offer frequent monitoring by means of weekly follow up with techniques to assess foetal well-being.
5. Induction of the delivery work is an invasive and painful procedure. For the purpose of taking an informed decision and giving their consent, women require sufficient and reliable information in addition to time to take the decision. They should know the method of induction, place, details, options on support and pain relief.
6. Identify by means of cardiotocogram those foetuses in a compromised situation in such a way that the appropriate measures are implemented to avoid irreversible damage. Commence the foetal well-being study after week 40 in cases of low-risk gestation. In cases of high-risk gestations, it will be the pathology itself that will indicate when and how often to perform the foetal well-being study.
7. Complete the gestation given any sign of foetal compromise. Oligoamnios may be a relevant data when the pregnancy is lengthened.

3.3.2.2. Prevention of diseases during pregnancy

It is fundamental to perform tests on which there is knowledge of their efficacy for pregnant women, with the purpose of identifying, preventing and treating early diseases or problems which affect their health and that of the unborn baby.

Anaemia

Aim:

Detect a possible anaemia and commence treatment to avoid effects on maternal and foetal health. Avoid the routine ingestion of iron by the pregnant woman due to the fact that there is insufficient scientific evidence to uphold this action and because of the adverse effects of this drug: constipation, diarrhoea, nauseas, epigastralgia and abnormal absorption of other substances.

Recommendations:

1. Offer all pregnant women tests to detect anaemia at the first pregnancy visit and at weeks 24-28 gestation by means of haemogram. Do not determine serum iron which leads to cases of over treatment.
2. Consider as a normal range up to 12 weeks haemoglobin equal or superior to 11 g/100 ml and 10.5 g/100 ml at 28 to 30 weeks gestation. If levels are lower, investigate the cause and assess the need for indication of iron supplements.
3. In the case of anaemia with suspected iron deficiency, the test of choice is determination of serum ferritin (90% sensitivity has been verified with a cut-off mark of 30 mcgr/l).
4. Commence treatment with iron if Hb<11 g/dl and/or haematocrit <33% during the first quarter, and if Hb<10.5 g/dl and haematocrit <32% during the second quarter.
5. Consider fasting prior to performing blood tests as unnecessary.

Incompatibility of Rh, blood group and indirect Coombs test

Aim:

Prevent maternal sensitisation and identify immunised pregnant women.

Recommendations:

1. Inform the woman of the suitability of administering Ig Anti-D during week 28 of gestation if there is incompatibility. Try to avoid routine

administration to all Rh (-) women in cases in which it is possible to identify with certainty the Rh of the biological father as this is a haemoderivative which is not free of risks.

2. Administer Ig Anti-D IM or IV (intramuscular or intravenous) before 72 hours postpartum, in Rh (-) women not sensitised and whose newborn is Rh (+). Administer an additional dose in case of foeto-maternal haemorrhage of more than 10-15 ml of foetal red blood cells (Kleihauer test). If not treated before 72 hours, following the delivery or sensitising events, Ig Anti-D should still be administered until 4 weeks.
3. Offer tests to determine blood group, Rh and indirect Coombs test for all women during the first prenatal visit or as soon as possible. The indirect Coombs test will be repeated at 26-28 weeks both for Rh negative and Rh positive women, to rule out Anti-D sensitisation and/or the onset of irregular antibodies.
4. Also administer following miscarriage or ectopic pregnancy, post-amniocentesis, choroidal biopsy, cordocentesis or ECV.

Infectious diseases

Aim:

Identify women at risk, prevent, detect early, diagnose and indicate the appropriate treatment for infectious diseases during pregnancy and avoid their sequelae.

Recommendations:

1. Perform uroculture at the first prenatal visit. Diagnose early the existence of asymptomatic bacteriuria and perform the appropriate treatment to reduce the increased risk of **pyelonephritis** and its consequences.
2. Identify women susceptible of being infected by **rubeola** during the pregnancy and offer vaccination postpartum to women not immunised to protect future pregnancies.
3. Identify pregnant women carrying the **hepatitis B virus** with the purpose of determining whether the baby requires immunoglobulin in addition to the antihepatitis B vaccine.

4. Ascertain the maternal serological condition to establish the study, monitoring and appropriate treatment of women living with **HIV**, to look after their health and reduce the risk of vertical and postnatal transmission. Refer pregnant women diagnosed with HIV infection so that they can be seen and treated by specialised teams.
5. Detect and treat early treponema pallidum infection (**syphilis**) to avoid sequelae for the mother and baby.
6. Advise pregnant women who have not had **varicella-Zoster virus** (VZV) to avoid risky contacts and immediately consult health personnel in the event of a potential exposure. Inform pregnant women who develop varicella or reveal a serological conversion that the risk of spontaneous involuntary miscarriage does not seem to be greater if varicella occurs during the first quarter, and that in the first 28 weeks of pregnancy there is a small risk of foetal varicella syndrome.
7. Offer serological screening for **Chagas disease** to Latin American pregnant women (with the exception of Caribbean countries where there is no epidemic), by means of the test with most sensitivity. Perform **parasitological tests** during the first 6-9 months and serological tests from then on to newborns to mothers with positive serology for Chagas disease; facilitate treatment to avoid the disease.
8. Take samples and perform cultures to detect women carrying the **group B streptococcus** with the aim of reducing the incidence of neonatal sepsis and administer antibiotic to the mother at the time of delivery according to the protocol. The professional seeing the pregnant woman should be informed that:

- There are recently published scientific articles and studies underway which question the need for universal screening. We need to ascertain the results of new investigations on the efficacy, cost-effectiveness and consequences of screening in addition to a reassessment of data available in clinical practice guides before making changes to the current protocol.
- Intrapartum antibiotics have reduced the incidence of neonatal sepsis and death by this germ. However, an increase in sepsis caused by other germs, especially those resistant to the antibiotic and with a similar overall mortality, is suggested.
- The influence of other factors not considered in prior studies on the onset of sepsis has been reported: intrapartum practices such as the use of internal monitor (increases the risk up to 8 times) and inappropriate practices which reduce the immune protection of the baby.

9. Perform practices which avoid endangering the baby's immune protection (save for exceptions which hinder this), and therefore may prevent **neonatal sepsis**:

   - Encourage all babies to take colostrum, because of its high concentration of immunoactive substances.
   - Ensure that the initial contact of all newborns is with their mothers for initial colonisation with their body's flora compared to the fact that there are specific immunoglobulins in the milk of these mothers. Avoid initial colonisation by flora from health personnel or health environment which is frequently more dangerous and entails more antibiotic resistance.
   - Avoid washing of vernix caseosa, as this contains antimicrobial peptides and proteins.
   - Ensure continuous mother-baby contact to avoid reduction in the immune response produced by stress and to facilitate successful maternal breastfeeding.
   - Promote maternal breastfeeding as the evidence reveals that this protects against late onset and probably early onset neonatal sepsis.

10. Do not advise discontinuing breastfeeding to carriers of HBsAg (+), as long as administration of Hepatitis B vaccine and gammaglobulin is confirmed prior to discharge from maternity.

11. Avoid universal serological screening for:

   - **Toxoplasmosis**, because of its low prevalence during pregnancy, the uncertainties posed by screening and possible teratogenicity of treatments.
   - Serology for CMV (**cytomegalovirus)**, although this may be assessed in women with a high risk of exposure or history of perinatal loss with undiagnosed cause.
   - Hepatitis C.

Gestational diabetes

There is controversy over whether to screen for diabetes for all pregnant women or only those who are compliant for risk criteria. We know that universal screening may lead to over treatment and selective treatment may lead to

cases not diagnosed. The evidence supports selective screening in countries with a low prevalence of gestational diabetes. In high prevalence countries such as Spain, we currently recommend universal screening (Spanish Group for Diabetes and Pregnancy). There are investigations underway to assess other screening and diagnosis alternatives.

Aim:

Perform early diagnosis of gestational diabetes to prevent complications in the mother and newborn.

Recommendations:

1. If selective screening is selected, this should be offered to women with the following risk factors: obesity (BMI > at 30 kg / m^2), age 35 or over, history of previous children of 4.5 kg or more, family history of first degree diabetes and/or origin from a country with a high prevalence of diabetes.
2. Respect the informed decision of women with no risk factors who decide not to undergo the screening test, after receiving the appropriate information.
3. Analytical tests to perform screening. The SEGO advises performing an oral glucose overload during the first quarter of pregnancy for pregnant women at risk with 50 g and extraction in 1 hour and for all pregnant women between 24 and 28 weeks. In the case of positive screening: oral glucose overload with 100 g, extraction in 3 hours. Recent publications from the International Study Group on Diabetes suggest performing overload with 75 g of glucose during a 2 hour curve.
4. Appropriately inform women so that they trust in their ability to give birth to a healthy baby free of complications as this kind of gestation ends satisfactorily in most cases with suitable diet, exercise and regular monitoring of glycaemia; in addition to offering them emotional support and simple access to the nursing consultation. It is not necessary to induce the birth for uncomplicated gestational diabetes.
5. Facilitate information on risks of possible contingencies; 10%-20% of women will require pharmacological treatment. Correct monitoring of glycaemia during pregnancy may reduce complications. If gestational diabetes is associated with fetal macrosomia, there is a small risk of dystocia of the shoulders. When macrosomia is diagnosed, estimate fetal weight and act according to the protocol. Favour in these special

cases maternal mobility during dilatation and expulsion, avoiding lithotomy. A case of gestational diabetes increases the risk of suffering from type 2 diabetes in the future, and it is appropriate to perform preventive medical consultation at the end of the gestation and breastfeeding period.

Fetal anomalies

Aims:

Prevent congenital neural tube defects by means of folic acid (FA) supplement. Identify chromosomal anomalies and malformations early by means of prenatal diagnosis techniques.

In case of a foetal anomaly (or diagnostic doubt), communicate this in the most suitable and empathic way in each case; and be available to the mother and partner in this situation of losing the baby they envisaged.

Recommendations:

1. Advise women who wish to become pregnant about the ingestion of a daily pharmacological FA supplement from three months from abandoning contraception together with a suitable and balanced diet, up to 12 weeks gestation. The recommended prophylactic dose of FA is 0.4 mg daily in women with no history of neural tube defects.
2. Inform women about FA-rich food.
3. Provide information on the prenatal diagnosis based on the evidence and aimed at preparing women to take decisions based on their own values and preferences, with sufficient time to decide whether they wish to be subjected to this screening and request clarifications. Inform about the scope and meaning of the tests and decisions that may be necessary to take during each one of the phases to screen for anomalies.
4. Choose to perform screening tests for aneuploidies with a rate of detection above 75% and rates of false positives lower than 3%. The following comply with these requirements: the combined test during the first quarter, the Quadruple Test during the second quarter and the integrated test or the integrated serological test during the first and second quarter.

5. The combined test from the first quarter (nuchal translucency, beta_human chorionic gonodotrophin (beta_HCG), pregnancy_associated plasmaprotein A) performed between 11+0 and 13+6 weeks is suitable and offers a good rate of detection of Down Syndrome and other chromosomopathies. It is simple to apply clinically and provides results during early stages of pregnancy.
6. Offer the triple or quadruple test (between 15+0 and 20+0 weeks) to women who attend monitoring late.
7. Offer to perform an ultrasound at 20 weeks, to screen for structural anomalies.
8. Inform about the possibilities of diagnosing structural foetal anomalies by means of ultrasound, in addition to limitations of the technique and different rates of detection according to the kind of malformation and other variables, such as BMI of the mother or foetal position during the examination. When a foetal anomaly is detected, women should be informed of its importance and attention paid to their feelings and emotions. All the information, advice and support necessary will be provided so that they can make a decision to continue or interrupt the pregnancy. Both decisions should be equally respected and each one of them will mean the appropriate care, interventions and recommendations which should immediately be made available to the women affected.

Iodine and vitamin deficiencies

Aim:

Prevent defects caused by moderate iodine deficits in newborns, guaranteeing the coverage of minimal iodine requirements so that the mother can prepare the thyroid hormones babies require during their pre and post natal development for correct growth of their brain and organic systems.

Recommendations:

1. Recommend the consumption of potassium iodide as a pharmacological preparation and under prescription by health personnel as the pregnant woman has increased iodine requirements during the entire period of gestation.
2. Recommend consumption of at least 200 mcgr/day for 3 months prior to the pregnancy, during the entire pregnancy and breastfeeding

period so that the mother can continue to provide their child with the iodine they require by means of maternal milk.

3. In areas with studies on the nutritional situation of iodine in the population, adapt these guidelines to their specific situation.
4. Inform and recommend the pregnant women to consume iodine-rich food (variety of fish, dairy products, etc) and to consume low amounts of salt but iodised (maximum 3 g/day compared to 9.7 g daily intake in Spain).
5. Regarding vitamins, inform that there is no scientific evidence which upholds supplementing healthy pregnant women with polyvitamin preparations during pregnancy for which reason they are not indicated during pregnancy.

Care during the delivery

3.3.3. Care during the delivery: Strategy for Care during Normal Delivery in the NHS

The EAPN within the NHS, under development since October 2007, aims to potentiate care during normal delivery within the NHS by improving the quality and warmth of care and disposing of unnecessary and damaging practices in light of scientific evidence and upholding current safety levels. This involves three transversal axes: multiculturality, disability and gender perspective.

The recommendations highlighted are grouped into four strategic lines: tackling the clinical practices based on best knowledge available; participation of women users in decision making; training professionals and research, innovation and dissemination of good practices. These recommendations are being implemented in the corresponding departments of the NHS with the backing of all Autonomous Communities, and therefore in the last few years they have had the coordination and financial support of the Ministry of Health and Social Policy (€8 million/year).

The document, prepared by all professional sectors involved in health care during the delivery and social and women's organisations interested in the topic, was approved at the highest institutional level in October 2007 by the CISNS plenary, thereby revealing the interest and will manifested and the

joint undertaking to improve health care in this field and make this a framework of reference for the entire country.

For its assessment, specific viable indicators are highlighted which may be obtained with existing information systems (CMBD) which facilitate monitoring the results (morbimortality) and some obstetric practices (episiotomies, caesarean sections). Process indicators are also proposed for the follow-up and implementation of the Strategy, such as recording the number of hospital maternity departments which include each one of the recommendations proposed in the Strategy in their protocol for care during delivery.

The IC, comprised of representatives of all Autonomous Communities, the TC, comprised of professional societies, social organisations and women's associations and the Women's Health Observatory which leads and coordinates this, are the entities responsible for driving this forward and following it up, in addition to its assessment plan for 2010.

The Strategy for Care during Normal Delivery within the NHS may be consulted at: **http://www.msps.es/organizacion/sns/planCalidadSNS/pdf/equidad/estrategiaPartoEnero2008.pdf**

Neonatal care

3.3.4. Care from birth to the first week of life

Aim:

Provide newborns with the best care for their health, well-being and adaptation to extrauterine life. Encourage, from the very first moment of life following the birth, the mother and baby to remain together to favour the emotional bond, closeness and maternal breastfeeding.

Recommendations:

1. Receive the newborn in an environment with a pleasant temperature to avoid energy consumption, cases of hypoglycaemia and secretion of catecholamines in response to the cold.
2. Avoid noise and conversations which interfere with the initial mother-newborn and father/partner-newborn contact facilitating the first sound heard by the newborn to be the maternal voice during vaginal or caesarean delivery.

3. Use materials which are not irritating or cold if there has to be contact with the baby's skin.
4. Clamp the umbilical cord when it stops beating to enable appropriate transfusion from the placenta. If you opt to donate the umbilical cord, determine the suitable time to puncture the cord and clamp according to the best available evidence as these are protocols currently in the process of review. Clamp the cord as late as possible to benefit the baby.
5. Bathing immediately or removal of the vernix caseosa to avoid loss of heat and interference with immediate skin to skin contact and olfactory and visual recognition is not recommended.
6. Have sidecar cots available in the maternity department and offer mothers the possibility of this kind of joint bed with their child to facilitate commencing breastfeeding.
7. Inform mothers and partners of the benefits of the joint bed and the way to use this safely.

3.3.4.1. Early skin to skin contact

Aim:

Encourage healthy newborns to position themselves on the mother's abdomen or breast immediately following the birth and therefore maintain intimate skin to skin contact.

Recommendations:

1. Have a written protocol agreed with the professional personnel participating in caring for the woman and their child following the birth and establish the responsibilities and actions which depend on each professional.
2. Place the newborns on the mother's naked abdomen or breast immediately following the birth, dry them, put a baby hat on and cover both without unnecessary interference or handling as, since they are healthy, they do not require any kind of resuscitation and the mother herself acts as a source of heat.
3. Maintain skin to skin contact of the mother with her newborn for at least 50 minutes without any interruption if the mother is in agreement.

It would be desirable to lengthen this to 120 minutes or at least until the initial breastfeeding has been performed.

4. When the mother's state of health does not permit skin to skin contact, offer the possibility of placing the newborn on the bare chest of the father, partner or companion as this will help to stabilise their vital signs, establish the emotional bond during subsequent commencing of breastfeeding and reduce crying time.
5. It is advisable for the process to be supervised by an expert professional.

3.3.4.2. Identification of the newborn

Aim:

Guarantee the right of newborn to be duly identified from the moment of the birth. Establish the necessary measures for unequivocal identification and regularise the sole recording of the newborn with their own identity from the time of birth.

Recommendations:

1. Guarantee quick verification of the newborn's identity in case of doubt.
2. Ensure verification of the identity of the baby and mother at the time of discharge.
3. Apply technological modernisation wherever possible which facilitates identification, data collection and use for which it would be advisable to set up a single deliveries and births registry with the purpose of having a unique and reliable source of information.
4. It is recommendable to have equipment, pockets and seals which include a bracelet to place on the mother's wrist, a bracelet for the newborn's ankle or wrist, an umbilical cord clip with a small label and a sticker to place on the birth record. The different items share the same number or barcode. Identification of the mother's fingerprint together with identification of the newborn's fingerprint has not been revealed to be very reliable at birth.

3.3.4.3. Unnecessary manoeuvres

Aim:

Facilitate the adaptation of the newborn into the extrauterine environment in contact with their mother, avoiding aggressive handling which may destabilise them.

Recommendations:

1. Do not separate the mother and newborn at any time following the birth. None of the procedures or tests applied to the healthy newborn require their separation. Do not prevent the uninterrupted presence of the companion if the mother wishes this.
2. During the first few hours of life the newborn should receive discreet observation and continued monitoring without interfering with the mother-baby contact to detect any clinical abnormality or sign which leads to suspecting the existence of any pathology in the child.
3. If the newborn has a good Apgar score they do not require any handling or resuscitation or aspiration of secretions.
4. Avoid inserting catheters during the immediate and subsequent postnatal period unless there is a clinical sign which indicates or leads to suspecting some malformation or pathology.
5. There should be *visual* confirmation during the first few hours of the existence of an anus, and the elimination of meconium during the stay in maternity should be monitored.
6. Avoid routine gastric lavage.
7. Avoid separation of the mother and newborn during any kind of test or treatment when there are deviations from health parameters save for justified exceptions.

3.3.4.4. Prophylactic practices and screening

Appropriate information should be provided to parents and they should participate or be present while these prophylaxis or screening practices are being performed. The following will be performed:

Prophylactic use of Vitamin K

Aim:

Prevent bleeding which occurs during the first few weeks of life in relation to vitamin K deficit.

Recommendations:

1. Administer vitamin K prophylactically following birth; administration of 1 mg IM is recommended to prevent classical haemorrhagic disease of the newborn (HD) and late-onset HD. This recommendation has been proven to be the most effective and easy to comply with for which reason it will be offered preferably and its suitability explained to the mother and father.
2. If mothers and fathers do not wish the IM guideline, the following oral guideline will be recommended which up to now has been revealed to be the most effective: 2 mg oral vitamin K at birth followed, in unweaned babies with total or partial breastfeeding, by 1 mg orally and weekly up until week 12. It is essential to make the mother and father aware of the importance of complying with this recommendation and not suspending oral administration prior to week 12.
3. For newborns < 32 weeks and < 1000 g: 0.5 mg IM or IV, and those weighing less than 1000 g regardless of GA: 0.3 mg IM or IV.
4. There will be an attempt to combine administration of vitamin K with other techniques which cause the newborn discomfort such as, for example, vaccination against hepatitis B virus (in the Autonomous Communities in which this is administered at birth). Vitamin K in any case, will be administered once the skin to skin contact time, immediately following the birth, has been completed.
5. Unless the mother wishes, the newborn will not be separated from their mothers' arms to administer vitamin K and we will try to perform the injection while the mother is breastfeeding. If it were not possible to place the newborn on the chest, they can be administered between 0.2 and 0.5 ml of 20% saccharose orally two minutes before and they will be offered a teat to suck.

Prophylaxis of neonatal ophthalmia

Aim:

Prevent conjunctivitis which occurs during the first 4 weeks of life and its possible late onset sequelae.

Recommendations:

1. Perform ocular prophylaxis on newborn to prevent neonatal ophthalmia by means of 0.5% erythromycin ointment or 1% tetracyclin ointment which has been revealed to provide equivalent protection against neonatal ophthalmia and have minimal side-effects; it is recommended for this to be used in single-dose format to increase safety.
2. Administer prophylaxis as soon as possible but respecting the skin to skin contact to favour the interaction between mother and child. This delay has not been revealed to deteriorate the efficacy of prophylaxis.
3. Prophylaxis can be dispensed if families request it as long as the mother has performed screening for STI during pregnancy and does not come from a country with a high risk of neonatal ophthalmia.

Vaccination for hepatitis B virus

Aim:

Prevent cases of cirrhosis and hepatocarcinomas.

Recommendations:

1. While there are no tests that reveal that coverage of perinatal maternal serological screening is optimal and that post-exposure prophylaxis reaches all newborns of mothers who are real and potential carriers of HBV, it is sensible to maintain vaccination for hepatitis B following the birth.
2. Administer the new neonatal vaccine early and always prior to discharge from the maternity department; in the case of children of mothers carrying the hepatitis B surface antigen (HBsAg), this will be applied together with hyperimmune immunoglobulin B.

3. Keep the newborns with their mother for vaccination against hepatitis B virus and maintain skin to skin contact postpartum at least 50-120 minutes if the mother so wishes.
4. Use non-pharmacological analgesic procedures during injection of the vaccine. Simultaneous breastfeeding with vaccination is the method of choice.

Screening for neonatal hypoacusia

Aim:

Detect hypoacusia early with the purpose of guaranteeing suitable development of language and early rehabilitation to improve prognosis both from the point of view of final hearing and communication.

Recommendations:

1. Perform screening for hypoacusia for all infants during the first month of life preferably before discharge after giving oral and written information to parents and requesting their consent. Those who do not undergo the test should receive audiological assessment during the first 3 months of life.
2. If there is no universal screening programme, efforts should be centred on identification of those indicators associated with any form of deafness and ensure that an objective test is performed as soon as possible to those presenting this.
3. Internationally accepted tests to perform auditory screening are transient evoked otoacoustic emissions (TEOAE) and automatic auditory evoked potentials (AEP). Both tests have proven to have high sensitivity for early detection of hypoacusia although the TEOAE do not examine the entire auditory tract and therefore have some limitations. Infants with no risk factors may be analysed with either technique.
4. Separate protocols for babies from neonatal intensive care units (NICU, level 2-3) and those from maternity are recommended. Breastfeeding babies with NICU stays of more than 5 days should be examined with AEP to avoid failing to diagnose neural auditory losses. NICU breastfeeding babies who do not pass the AEP test should be given a direct appointment with Ear, Nose and Throat specialists for reassessment including AEP and TEOAE if this has not been performed during the screening phase.

5. Deliver information on the results to parents and record the results of the tests in the child health document.
6. Perform follow-up of all cases detected in addition to appropriate early treatment.
7. Breastfeeding babies who present indicators of risk of neurosensory deafness acquired gradually and late-onset should be monitored periodically up until the age of 3.
8. Collect quality-control indicators from the programmes.

Neonatal screening for genetic and endocrino-metabolic diseases

Aim:

Reduce, by means of early detection and early commencing of treatment, the incidence of psychic and physical disabilities caused by endocrine and metabolic diseases present during the neonatal period and which are the object of screening.

Recommendations:

1. Take the paper blood sample from the heel prick test for all newborns from 48 hours of life as soon as possible and in sufficient amount so as to avoid false negatives. Specific protocols to collect samples in case of premature babies, serious cases and monozygotic twins will be established.
2. Perform the sample for neonatal metabolic screening before day 4 or 5 of life as detection of metabolic disorders and commencement of possible treatments should be considered top priority.
3. Recommend a second sample between week 2 and 4 in premature babies with birth weight under 1500 g, serious cases and monozygotic twins.
4. Breastfeeding for at least 5 minutes before the heel prick test is the most effective analgesic technique to avoid pain during blood sampling. In most cases where it is not possible to place the newborn on the mother's breast, they may be administered between 0.2 and 0.5 ml of 20% saccharose orally two minutes before, and use other methods such as appropriate nesting or containment and non-nutritional suckling.

5. Sensory stimulation, whether by means of massages, caressing, skin to skin contact, visual content, using a dummy (if the mother is not present) and containment may reduce the painful response, regardless of association with maternal breastfeeding or administration of saccharose.
6. Avoid the use of iodised antiseptics during the perinatal period both in the mother and baby to avoid the onset of transitory hypothyroidism and avoiding false positives for the screening test.
7. Verify in the primary care centre that the newborn has been subjected to metabolic screening and that there is documentary record of this both in the clinical history and child health document. The result should also be recorded.
8. In case of doubt over whether the screening has been performed, the reference unit will be contacted and as appropriate, this will be determined immediately and the sample referred to the reference laboratory.

3.3.4.5. Early postnatal hospital discharge

Aim:

Encourage discharge between 24 and 48 hours following uncomplicated vaginal delivery and uncomplicated birth at term in coordination with primary care departments.

Recommendations:

1. Have a written protocol available in maternity departments on this procedure.
2. Assess whether the mother is capable of looking after her newborn herself before deciding to discharge.
3. Provide the family with a report on care, interventions and plans performed and those proposed for the next few days.
4. The domiciliary visit of the primary care midwife should be arranged from the maternity department or, if this service does not exist, the appointment will be agreed with the primary care centre of reference for the third and fourth day of life.
5. Offer an early neonatal visit during the third or fourth day of life if possible at home to care for the mother and infant and to be made by the primary care midwife or nurse.

3.3.4.6. Early neonatal visit in the health centre or at home

Aim:

Ascertain the physical and emotional setting of the family, deal with doubts of care, assess feeding problems with quiet observation of grip, suckling and breastfeeding posture, recognise the state of health of the mother and the newborn during puerperium, and provide continuous health care from the viewpoint of preventing the disease and promoting health, dealing with maintenance of maternal breastfeeding, detection of problems and preventing cases of rehospitalisation.

Recommendations:

1. Perform the visit (preferably at home if possible) by the midwife or nurse trained in neonatal and puerperium care for the mother and the newborn during the first week of life.
2. The opportunity to recognise the physical, emotional and social environment of the family, dealing with feeding and puerperium care problems early on is an important activity with no evidence against it to decide upon the provision of care for the family over the next few weeks.
3. Perform care (including for the case of exclusive maternal breastfeeding) in the primary care centre 48-72 hours following discharge from the maternity department or in any case before the end of the first week of life.

3.3.5. Promotion of maternal breastfeeding

Aim:

Facilitate newborn's access to breastfeeding and promote breastfeeding as the most healthy feeding option considering the mother's circumstances.

Recommendations:

1. Agree and write **regulations to promote and support maternal breastfeeding** by personnel responsible for mother-child health care, mothers' representatives and the administration.
2. Facilitate **training multidisciplinary health personnel** to incorporate knowledge, skills and attitudes and good practices related to maternal breastfeeding, which enable effective help for women who wish to breastfeed. Ensure common quality criteria during training courses.
3. Provide **information to pregnant women** to increase their knowledge and skills on how to feed their children as best they can by explaining breastfeeding benefits and techniques and providing information on existing breastfeeding support groups and encouraging them to contact them.
4. Respect the initial alert period of the baby and state of maximum maternal sensitivity triggered by the endogenous release of oxytocin to commence **maternal breastfeeding during the first hour of life**.
5. Provide help for mothers to **continue breastfeeding** by means of health personnel (mainly nurses and midwives) and breastfeeding advisors or support groups.
6. Encourage **exclusive natural feeding** and avoid artificial milk, glucose solution or water before the first breastfeeding when there is no medical justification in maternity departments. Also avoid the use of pacifiers and teats during the first few days; should it be necessary to administer supplements, there are alternatives with the feeding bottle as a last resort. Comfort and convey confidence to the mother when the volume of maternal colostrum is insufficient and inform about measures that will help to increase its production and consider donated pasteurised human milk as preferable to other supplements.

7. Promote maternal **free demand** breastfeeding so that babies have access to breastfeeding without restrictions as to the duration and frequency of doses.
8. Inform mothers, parents and carers who wish to feed their babies with formula milk about the best way to do this to guarantee **that feeding with breast milk substitutes** be carried out in the safest way possible with the purpose of encouraging child health and development and covering their nutritional needs.
9. Apply the **trade code for breast milk substitutes** with the purpose of protecting maternal breastfeeding from deceitful advertising practices which lead to abandoning this.
10. Include in the Child Health Report Card, the new child growth pattern **(WHO growth curves**) **http://www.who.int/childgrowth/en/** which presents the following characteristics:
    - This establishes maternal breastfeeding as the biological "rule" for the breastfeeding baby as a benchmark pattern to determine healthy growth. This ensures for the first time coherence between the instruments used to assess growth and national and international guidelines on child feeding which recommend maternal breastfeeding exclusively for 6 months and subsequently with food supplements up to the age of 2 and beyond.
    - It also provides for the first time scientific data and guidance on the way children grow all over the world. To date, growth curves simply reported how children grow at a determined time and place. Currently, they present trends on obesity; growth curves up to now tended to "normalise obesity". However, curves from the WHO report the growth standard under optimal conditions which has an international pattern valid all over the world both in developed and developing countries.
    - It confirms that for all children born anywhere in the world, if they receive optimal care from the start of their lives, have the potential to develop within the same range of weights and heights during the first 5 years of life, and reveal that differences in child growth up to the age of 5 depend more on nutrition, feeding practices, the environment and health care than genetic or ethnic factors.
    - It provides a set of growth indicators which enable comparing the growth parameters such as weight and length/height of breastfeeding children with an optimal reference value, providing early identification and prevention of malnutrition, obesity and related health problems.

- This is an important and valuable instrument for health professionals as it enables assessing the growth and development of children individually and collectively.
- Currently, there is a broad international consensus on the utility of the WHO growth patterns to assess growth during childhood from 0 to 5 years because they define maternal breastfeeding as the regulatory model for growth and development and the best description of physiological growth at this age. For these reasons, we consider that new curves from the WHO provide substantial advantages that should be incorporated into the clinical primary-care history without this meaning phasing-out of the current curves.

11. Promoting institutional change aimed at improving practices and routines performed on mothers and infants and disseminating recommendations by the WHO/UNICEF and their programme for accrediting IHAN [Initiative for Humanisation of Care During Birth and Breastfeeding] centres.

3.3.6. Care of the hospitalised newborn

Neonatal units require a new family-centred care approach based on a change in attitude which recognises the family as a permanent reference during the child's life. Parents are natural carers and should form part of the care team together with professionals. Newborns have a right to receive this maternal and paternal care.

3.3.6.1. Participation of families in neonatal units

Aim:

To recognise the family as a permanent reference during the life of newborns even during their hospitalisation, facilitating its involvement in care and participating in decisions and representing a very valuable support for the infant and for the team of professionals.

Recommendations:

1. Favour physical contact (even 24 hours a day) and interaction of newborns with their mothers and fathers as this has proven to be beneficial for both adults and children.

2. Personnel from the neonatal unit should care both for babies and mothers and fathers.
3. Unless medically indicated, sick newborns should not receive anything other than maternal milk.
4. Newborns hospitalised in neonatal units should also be in skin to skin contact with their mothers and fathers for as long as possible.
5. Visits to babies should be permitted from mothers and fathers and other members of the family such as siblings and grandparents.
6. Allow joint mother-newborn transfer in skin to skin contact with stable and non-serious cases for conventional and lower risk transfers.
7. Avoid the newborn being transferred into incubators which do not have standardised safety devices.

3.3.6.2. Mother/father kangaroo care

Aim:

Encourage the health and well-being both of premature newborns and their mother and father by means of this method as an alternative to incubator care.

Recommendations:

1. Promote kangaroo care during admission of all newborns to the neonatal unit as this has proven to have benefits in terms of health, not only physical but also mental, both for premature babies and their mothers and fathers.
2. Perform painful procedures, if possible, during kangaroo care.
3. Following the discharge, if the baby has not reached term age, kangaroo care can be continued at home with the appropriate support.
4. Have a written protocol on kangaroo care in all neonatal units.

3.3.6.3. Non-pharmacological analgesia

Aim:

Tackling prevention and treatment of pain of newborns is an essential human right and avoide its consequences such as abnormalities in cognitive development and learning and an increase in morbimortality.

Recommendations:

1. For the term newborn, as long as their condition does not contraindicate this, painful procedures will be performed during breastfeeding and at least two minutes from having commenced breastfeeding.
2. When breastfeeding is not possible, administer infants with 20% saccharose (0.2-0.5 ml) 2 minutes prior to heel prick tests, venipuncture and other painful procedures.
3. If the baby cannot be breastfed during the procedure, offer the possibility of suckling during the procedure.
4. For premature newborns, painful procedures will be performed during the kangaroo position whenever possible.
5. During painful procedures nesting or containing manoeuvres will be applied to babies.

3.3.6.4. Environmental care and conditions

Aim:

Implement the measures that should be present when performing any care or procedure, both medical and nursing, aimed at respecting wherever possible the right of the newborn to rest, silence, darkness, proximity, pain relief and personalised care both for them and their family.

Recommendations:

1. Reduce levels of noise and light to favour the sensory development of newborns and improve the quality of care and communication of professional personnel.
2. Provide a flexion position with support of the appropriate limbs and facilitate finding the median line.

3. Nesting or containment in addition to comfort should be provided.
4. Keep noise levels of neonatal units below 45 dB (10-55 dB). A maximum of 65-70 dB is temporarily accepted.
5. Place visible sound meters on the walls of rooms that may help to adapt the level of tone of voice, levels of alarms and respirators and monitors, etc.
6. Keep recommended lighting levels in the NICU where there are very premature babies between 1 to 60 lux in the cot or inhibitor (babies under 30 weeks gestation should be at least 20 lux).
7. Avoid exposure to direct lights in premature babies. Place them in dark places or cover their eyes during procedures in which high light intensity is required. If they come out for kangaroo care, they should be provided with a semi-dark environment. Only in this case will they open their eyes and permit appropriate interaction.

3.3.6.5. Maternal breastfeeding in sick babies

Aim:

Inform mothers of hospitalized babies the importance of breastfeeding (BF) to aid in the recovery of their children, advice on extraction and transporting of breast milk, and ensure mothers open access to their children in order to facilitate breastfeeding during the stay of their babies in inpatient units.

Recommendations:

1. Instruct mothers who have to separate from their sick or premature baby on manual extraction techniques for use of double electrical milk extractors and highlight the importance of commencing extraction as soon as possible at least during the first 6 hours post-partum. These instructions will include:
   - Extraction at least 5 times a day and one of these at night for 15 minutes each time (or until the milk stops flowing).
   - Become familiar with techniques which favour the milk ejection reflex prior to extraction (application of heat, massages, relaxation and others).
   - Storage, conservation, labelling and transport appropriate to maternal milk to be able to offer help to their children under optimal conditions.

- Information on how the double extractor can be obtained before hospital discharge.

2. Encourage mothers to breastfeed on demand as soon as the baby's situation so permits during hospitalisation.
3. Institutions will promote an open-door policy in neonatal and breastfeeding units to favour breastfeeding and accompany sick breastfeeding newborns and babies by offering support to mothers and practical help with food and appropriate places to rest next to their children.
4. Promote the implantation of donated human milk banks and encourage mothers to participate in these. Donated human milk from the bank will always be considered as an initial alternative if this is available for sick newborns who do not have sufficient help from their own mother. This alternative will be offered and explained to mothers and family members.
5. In case of caesarean delivery, permit the mother to perform skin to skin contact with the newborn from the time of birth, in the operating room itself and avoid separation during resuscitation hours. These women require more support and help to care for their newborn and commence maternal breastfeeding, for which reason they should be permitted to be accompanied all times by the person of their choice.

3.3.6.6. Safety of newborn patients

Aim:

Reduce the damage to newborns by means of reduction of foreseeable adverse events both due to human errors and system failure.

Recommendations:

1. Improve the culture of security in professional personnel by means of creating and maintaining the following structures:
   - Updated clinical practice guides/protocols and aimed at standardising care during the time of most risk for the newborn, at least during foetal monitoring, neonatal resuscitation and intrapartum massive haemorrhage.

- Guarantee effective training of all personnel involved in risky situations.
- Create a perinatology committee to review protocols and actions and propose actions for improvement.
- Create a system for notification and learning from incidents and adverse events.

2. Unequivocal identification of the newborn which includes:
   - Identification of the mother-child binomial
   - Reliable, universal and unequivocal identification of the newborn and which must be used to perform tests and administer medication or haemoderivatives.
   - Creation of safety guidelines for the institution aimed at avoiding theft or switching of newborns.
3. Reduce infection
   - Infection associated with health care
     - Availability of hydroalcoholic solution at all care points.
     - Implementation of the five steps of the WHO for hand hygiene.
     - Implant zero bacteraemia protocol for insertion and maintenance of central catheters.
   - Vertically transmitted infection
     - Implant and monitor compliance with guides to reduce the risk of infections from mother to child: hepatitis B, HIV, streptococcus agalactiae, etc.
4. Reduce adverse events related to medication with a special emphasis on:
   - Calculation of the new medication by two people.
   - Avoid abbreviations or define a protocol to use in the unit.
   - Define a protocol for standardised dilution of medication.

Care during the puerperium

During this period of readjustment in the life of women, their families and close surrounding circle, it is important to offer quality healthcare and help women to experience this complex process in a calm and satisfactory way.

The WHO manifests that it is essential to have evidence-based protocols on care during the puerperium to ensure good practices. Therefore, it is necessary to identify the care that all women and their babies should receive during the first few weeks following the birth, recognise and appropriately treat any deviation in normality, and eliminate those practices not backed by scientific data or which prove to be damaging and unnecessary.

3.3.7. Care during puerperium

Aim:

Promote the health of women in the puerperium dealing with the physical, emotional and psychological changes which occur during this period and facilitate the advice and care necessary for their well-being.

Recommendations:

1. Convey that the birth of a child requires a significant **adaptation** and restructuring for the woman during the puerperium. The psychological and emotional adjustments are characteristic vital stages of transition and facilitate adaptation to the change.
2. Establish routines to examine the **emotional well-being** of the woman during the puerperium, the support received from her surrounding circle in addition to psycho-emotional strategies and resources to handle daily matters. Facilitate communication between families/partners and health professionals to detect changes in mood or the woman's normal behaviour. Explain the normal changes in the emotional state during the puerperium to the woman and her partner.
3. Respect the need for sufficient rest and hours **of sleep** from the mother's stay in maternity. Encourage rest when the baby sleeps.
4. Promote a **family environment** which supports women during the puerperium and ensures necessary rest. Advise people who share the household being responsible for daily tasks to optimise the mother-baby relationship, encourage the emotional bond and closeness and favour maintaining breastfeeding free of complications.
5. Promote the mental health of the woman during the puerperium and encourage her self-care and **empowerment**. Promote the personal psychological resources of each woman and her family to facilitate

the transition and promote secure attachment, breastfeeding, respectful child-rearing and formation of women's social networks.

6. Develop a **personalised and documented plan** for care during the puerperium as soon as possible after the birth and even during the prenatal period.
7. Train women to understand the normal changes in the body during the puerperium and detect possible problems.
8. Appropriately inform about **care of the perineal area**, how to do exercises to recover and the most suitable time.
9. Advise women about the **physical activity** during the postpartum which is suitable for their prior conditions, characteristics, preferences and needs.
10. Warn women during the first puerperium visit of the signs and symptoms of **serious complications** so that they immediately contact their health professional or request help from the casualty department.
11. Recommend suitable **nutritional support and liquids**, especially if they are breastfeeding.
12. Promote a **broad vision of experiencing sexuality** during the puerperium not focused on coital activity. Encourage the creation of trust between women and their partners together with primary care professionals to tackle possible difficulties and/or experiences regarding sexuality during this period.
13. Provide contraceptive advice and deconstruct false myths and beliefs.
14. Detect signs and/or symptoms of problems **in the breasts.**
15. Promote maintenance of maternal breastfeeding:
    - **Support the continuity of maternal breastfeeding**. One of the aspects which can most help to maintain maternal breastfeeding is to follow-up the breastfeeding baby with **growth curves from the WHO**, as because breastfed babies gain less weight than those fed with feeding bottle, they can be diagnosed erroneously with insufficient weight gain and a mixture of mixed or artificial breastfeeding is introduced.
    - Make health professional personnel aware of existing resources for consultation in case of **administration of drugs** to the breastfeeding woman, train them to ascertain the basic notions of prescription of drugs during breastfeeding and inform them of the half a dozen maternal diseases which contraindicate or virtually make breastfeeding impossible.

- Prevent health problems of the breastfeeding woman and her child arising from exposure to **risks at work and environmental toxic substances.**

16. Facilitate women with appropriate information on different options for feeding their newborns when they **return to work** and the risks and benefits arising from this. Inform about the compatibility of work and breastfeeding.
17. Favour **communication-verbalisation by the woman of her emotions during the puerperium**, especially those considered negative: feelings of inadequacy, non-adaptation, incapacity, tiredness, anger, rejection, etc. to avoid the consequence of guilt and onset of depressive feelings and states. This task should also be facilitated with the father to favour his involvement/well-being and to avoid the emergence/aggravation of physical and/or psychological violence against women and their newborns.

3.3.7.1. Potentiation of breastfeeding self-help and support groups

Aim:

Make visible the importance of social organisations and voluntary organisations of mothers and fathers with personal experience and additional training on maternity, paternity and maternal breast feeding.

Recommendations:

1. The professional person responsible for guaranteeing care of the mother and newborns should be familiar with groups already established in their area and facilitate contact with mothers, fathers and families.
2. Facilitate the exchange of information and ideas between groups and professionals which provide updated scientific information and recommendations to handle the most frequent breastfeeding problems.
3. The most appropriate channels should be set up to place mothers who require support from hospitals and medical centres in contact with support groups and vice versa.
4. In case there are no previously established support groups the creation of these should be encouraged.

3.3.7.2. Care in more vulnerable situations

Aim:

Facilitate professionals who see women during the puerperium to become familiar with the characteristics and needs of women found to be in especially vulnerable situations. Have written protocols for action in hospitals and primary care centres.

Recommendations:

1. Facilitate professionals being able to identify more vulnerable situations, avoiding the stigmatisation of women.
2. Having written information in protocols for care during the puerperium which define the necessary actions of these groups of women.
3. Eliminate barriers arising from specific needs of women from other cultures and with different skills.
4. Facilitate simple and quick access to psychosocial health professionals for women in vulnerable situations (women alone, adolescents, etc, those in situations of social risk or who have undergone gender violence).
5. Avoid the adoption of special measures which may discriminate.
6. Health personnel should ascertain the risk factors, signs and symptoms of gender violence and know how to proceed following the guidelines of the "Common protocol for health action to respond to gender violence"[13].

[13] http://www.msc.es/organizacion/sns/planCalidadSNS/pdf/equidad/commonprotocol.pdf

3.3.7.3. Support in situations of loss and mourning

Aim:

Direct care focused on the needs of the woman and her family or surrounding circle. Facilitate professionals seeing women after a perinatal loss to help them to become familiar with the appropriate protocols for action in these situations.

Recommendations:

1. Have written protocols known by all personnel based on scientific knowledge which focuses care on the human aspects.
2. Respect the individual needs expressed by women and their companion(s) and offer them physical spaces and time for intimacy, the possibility of seeing and being with their baby and hugging the baby if they so wish as well as respecting her decision not to do so.
3. Offer the possibility of keeping some special objects to remember the baby.
4. Refer to the baby using their name. Give an explanation and respond to queries whenever necessary on what has happened.
5. Involve the mother and their partner in decisions regarding the destination of the baby's body while respecting the decision.
6. Offer psychological help. Do not minimise pain, permit expressing this without judgement by means of listening empathically.
7. Advise the mother on inhibition of both natural and pharmacological breastfeeding or weaning.

3.3.8. Health care during the puerperium

Following the birth women face a new and complex situation. First, they experience a physiological readjustment, physical and emotional changes and the need to recover given the tiredness because of the effort made. At the same time, care of the baby requires a continuous state of alert and effort to adapt to the new situation especially during the first few months which can absorb a large part of the mother's energy and time.

During this new stage it is difficult to combine care of the baby, self-care and habitual tasks for which social relationships and leisure activities are restricted or disappear completely. In addition, it should be considered that after the birth, the focus of the family and social care turns from the woman to the baby and the mother is frequently relegated to a second position. Paradoxically, the hormonal state during the woman's puerperium, especially if she opts for maternal breastfeeding, guides her towards care of her new child and she sometimes self-imposes intellectual tasks, which at times are demanding or external pressures, and she may choose to postpone these for one or a few months if this does not harm her working or social life always from personal choice. Knowing that this is a passing and physiological process may help to understand the states she is experiencing and make decisions to carry out the required adjustments to her family, working and social life.

In this context the onset of physical and emotional problems in women which tend to increase over time, is frequent. Back and head pains, extreme tiredness as well as anxiety and depression interfere particularly in the daily routine of women and often make them feel guilty for not responding appropriately to the image of a confident, happy and healthy mother.

Because of all this, the puerperium represents the stage in which special attention should be paid to women to promote their health, prevent possible problems and support their well-being, favouring and advising full involvement of the partner, family support and social self-help networks.

3.3.8.1. Scheduled visits and examinations

Aim:

Perform follow-up of the evolution of the puerperium with a schedule of close-knit and continuous care between the hospital stay and discharge, and ensure that both health personnel and women know the optimum time to make visits during the puerperium, their content and aims.

Recommendations:

1. During the **first 2 hours** make uninterrupted skin to skin contact and facilitate spontaneous and uninterfered initiation of maternal breastfeeding. Perform follow-up of the physical state of mothers to monitor their normal recovery without interfering with the mother-baby union. Be alert and follow written protocols to detect any sign or symptom in relation to hypovolaemia, excessive bleeding, urinary retention, fever, infection, respiratory difficulty, intense headache or other abnormalities.
2. During the **first 24/48 hours**, continue assessing maternal health by means of written protocols and prepare, together with the woman, a schedule for personalised care. Support women during maternal breastfeeding or inform them if they opt for artificial feeding. Facilitate the opportunity to talk about their delivery.
3. Following hospital discharge, ask women **during each puerperium visit**, about their physical and emotional well-being, their family and social support and their strategies to handle daily matters.
4. Offer information and advice at each puerperium visit to help to assess the baby's general condition and **identify the signs and symptoms** of health problems.
5. During the **first week** offer immunisation to Rh-negative women. Assess constipation and other symptoms. Observe the mother-newborn relationship and assess the support from the family or surrounding circle.
6. At **2-8 weeks postpartum**, inform women and their partners about the characteristics of sexuality and contraception during this period. Offer all women a check up **at 6-8 weeks** which focuses on their physical and emotional health. Notify them to contact a professional in case of vaginal bleeding, severe or persistent pain or any anomaly which restricts daily activities.

3.3.8.2. Prevention and care of physical abnormalities

Aim:

Detect the onset of problems, facilitate quick and effective care and prevent possible complications.

Recommendations:

1. Ask women at each puerperium visit if they have discomfort or any concerns about the process of healing of any **perineal wound or**

episiotomy and assess signs and/or symptoms of infection or dehiscence and offer an examination. Explain to women the importance of personal perineal hygiene and how to carry this out.

2. Offer an assessment of the perineum to women who experience **dyspareunia** at 6 weeks following the birth. Ask and notify women to whom epidural or spinal analgesia has been applied to consult in the event of any severe **headache or migraine** at each puerperium visit. Similarly, offer advice and relaxation, rest, sufficient sleep on how to avoid factors associated with the onset of migraines.
3. Assess the underlying physical, psychological and social causes if there is **persistent puerperium fatigue** which affects the way in which the woman looks after herself and her baby and, as appropriate, offer advice on diet, exercise and planning activities including time spent with their babies and help they receive in the tasks performed.
4. Offer advice to women with **constipation** and discomfort, assess diet and intake of liquids and treat with a mild laxative if dietary measures are not affected. Advise dietary measures to women with **haemorrhoids** to avoid constipation and offer monitoring based on local treatment protocols and assess those more severe cases if they require urgent treatment.
5. Ask women during the puerperium about **faecal incontinence**. Assess the severity, duration and frequency of symptoms and explain self-care. If these do not resolve or are severe initially, refer for a detailed assessment by expert professionals.
6. Explain pelvic floor exercises and good habits to women with involuntary losses of small amounts of urine. Assess and perform specialised treatment for **urinary incontinence** by physiotherapists in those cases which do not resolve or worsen.

3.3.8.3. Care of mental health problems

Aim:

Prevent and identify early psychopathology postpartum, facilitating specific care for different needs of women because of culture, language, different capacity, beliefs, etc. Establish diagnostic criteria and, as appropriate, refer for their treatment.

Recommendations:

1. Favour maternal sleep during the immediate puerperium. Do not awaken mothers during their stay in maternity for non-urgent tests and procedures and favour and permit the safe joint bed (sidecar cot, large bed....). Inform mothers of the importance of sleeping or resting during the first few days each time the baby sleeps as a way to prevent postnatal depression.
2. Identify the signs and symptoms of maternal mental health problems (postnatal depression, puerperium psychosis, postpartum post-traumatic stress disorder, etc.) which they could experience during the weeks and months following the birth, recommending preventive companionship (by a person close to the woman and/or mental health professional) and close follow-up.
3. At each puerperium visit examination of the woman's emotional well-being, support received by the surrounding circle and her resistance and resources to handle daily matters is recommended. Communication between their families/partners and health professionals should be facilitated to facilitate detection of changes in mood and behaviour.
4. In the treatment plan for mental health disorders during the puerperium the infant and the partner will always be considered.
5. Perform prevention actions in relation to postpartum post-traumatic stress disorder (PTSD): make professional personnel aware of the symptoms, risks and consequences of PTSD for the health of the mother/infant; implement good care practices in the delivery which reduce the risk of presenting PTSD; facilitate psychological care to women affected and close follow-up during their difficulties with maternity from primary care.
6. Facilitate professionals caring for mothers, babies and families to be familiar with the emotional states not considered pathological for the normal puerperium, the way to help them understand and handle, and differentiate symptoms or signs of psychopathology in addition to the way to prevent disorders arising from lack of sleep, emotional companionship or lack of information.

3.3.8.4. Characteristics of the puerperium following caesarean delivery

Aim:

Inform women during the puerperium and their partners, family members or companions about the care a woman requires following a caesarean and prevent, detect and resolve specific physical, psychological and social health problems which these women face.

Recommendations:

1. Promote good practices which favour the recovery of the woman and minimal emotional, personal and family impact. Favour maternal breastfeeding following a caesarean by means of starting immediately as in a normal birth and facilitating extra support during their stay in the centre.
2. Perform mother-baby skin to skin contact early immediately following the caesarean in the operating room except when there are complications which hinder this. Permit the presence and companionship of the father or partner during the process whenever the woman requires this.
3. Provide suitable and sufficient analgesia which is recommended and not on demand. Have written analgesia protocols following caesarean delivery.
4. Have a written protocol which covers post-caesarean care.
5. Assess the woman's state of emotional wellbeing during the hospital stay and discharge, remaining alert to signs or symptoms of psychological discomfort or postraumatic stress syndrome.

3.3.8.5. Detection and tackling serious complications

Aim:

Identify and treat in time those complications which may endanger the life of the woman and have written protocols available. Inform and instruct women and their families to be able to detect signs and symptoms of alarm without causing worry when there are no complications.

Recommendations:

1. Assess any abnormality in **vaginal bleeding**, position and/or size of the uterus. Follow a protocol for urgent action if deviations from normality are detected.
2. Measure blood pressure following the birth at least once and document this within the first 6 hours following the birth according to written protocol. If there are symptoms of **pre-eclampsia** repeat the determination and if this is accompanied by another sign or symptom assess emergency action.
3. Encourage women to start moving around as soon as possible following the delivery. Pay special attention to obese women or those with varices as they have more risk of suffering from **thromboembolic** complications.
4. Assess the possibility of **deep venous thrombosis** in those women with unilateral pain, reddening or inflammation of the lower limbs (emergency action).
5. Assess women with respiratory difficulty or thoracic pain to rule out a **pulmonary thromboembolism** (emergency action).

Transversal aspects

To attain the objectives set out in this ENSSR, it is necessary to act in the different fields from the different viewpoints and with the different aspects which play a role in the care of the reproductive process. It is inevitable to ensure that professionals and users have a detailed understanding of what a change in paradigm in care of the birth process entails.

First, this requires the undertaking and drive from institutions. In this case, the MSPS is promoting the development and implementation of this Strategy and Autonomous Communities show their undertaking to bring into practice in their regions the aims and recommendations set out.

The contribution of scientific societies and professionals is also necessary; they have already made progress in the last few years in this direction by preparing new protocols which focus care on respecting the physiology and non-intervention as long as there is no clinical indication for this. Special attention should be paid to human and family aspects with the purpose of disseminating among all professionals this new approach based on scientific evidence and current knowledge.

Secondly, the active participation of women in their own process and the support of partners or companions they select are essential. Women should have all the appropriate and comprehensible information on the necessary companionship by expert personnel, and the empathy of people from their circle to feel safe and not alone, be able to express their wishes and needs, take the most appropriate decisions and thereby develop their entire potential.

3.3.9. Training professionals

The EAPN in the NHS considers one of its priority strategic lines the training of professionals (midwives, gynaecologists, paediatricians, anaesthetists and nursing personnel) in relation to the delivery and birth process.

On the other hand the ENSSR upholds this priority and highlights as a transversal strategic line for all levels of care during the reproductive process and for all professional sectors related to care of women, infants and families during this unique and single experience in their lives.

One of the biggest difficulties to alter routine clinical practices and improve the quality and warmth of care is found within the training received. It is necessary to update knowledge and skills and go further into depth in understanding the physiology of the delivery from a gender perspective and keeping present that this is hospital care for a health process not a disease.

The content of professional training has to reflect updated knowledge based on scientific evidence available and it must form part of regulated specialised training programmes in obstetrics and gynaecology, paediatrics, anaesthetics and obstetric-gynaecological nursing (midwifery). This should also be considered in continuous training programmes for all personnel related to the reproductive process including the possibility of performing training courses for trainers so that they can reach more professionals more quickly.

Therefore, it is considered necessary to promote a change and it is therefore essential to drive training of professionals so that they have a detailed understanding of the involvement of evidence-based care currently available and the benefits of the medicalisation of normal health processes, differentiating them from pathologies for which there are other resources.

Aims:

Make NHS professionals aware so that they include the aims and recommendations of this strategy in their clinical and care practices.

Update the knowledge and skills of health personnel related to the reproductive process based on scientific evidence and existing good practices.

Recommendations:

1. Perform training activities as an effective means to change practices, attitudes and aptitudes with appropriate comprehension of the change in paradigm during care of the delivery and birth process based on respect for the woman and physiology as the best method to ensure healthy and satisfactory care free of complications.
2. Continue the training undertaken from the Training Programme of the EAPN and perform training courses to train in all Autonomous Communities and therefore reach more professionals more quickly to drive forward changes in practices all over Spain.
3. Train health and auxiliary personnel from these departments to improve communication with women and families.
4. Incorporate recommendations considered in the pregnancy, neonatal and puerperium sections of this strategy, in all continuous training programmes for professionals related to the reproductive process.
5. Consider the aforementioned recommendations in training of the medical speciality in obstetrics and gynaecology, paediatrics, anaesthetics and obstetric-gynaecological nursing (midwifery). Drive the restructuring of study and coordination plans with national committees on specialities and between health and education departments.
6. Finance training activities in projects which autonomous administrations present to be subsidised by the MSPS.
7. Facilitate information and training for temporary personnel from these departments by means of written protocols which are either visible in units or systematically delivered upon commencing their work in the unit.
8. Facilitate information to professionals on the specific needs and problems of immigrant women or those from other cultures, adolescents, those with differences in capability, and those with a history of gender based violence and/or sexual abuse, and possible signs, symptoms and reactions these women may represent whether they are aware of the history or not. Set up support and follow up channels for these women.

3.3.10. Participation of women and partners

The gradual medicalisation of the reproductive process in the last few years has led to an excess in health interventions which has led to the invisibility of the principal role of women and also distancing or absence of the role of the father or partner and their emotional support environment.

For there to be real participation of women and their partners it is necessary to have an overall information on the process, specific information on each one of the stages and on the existing facilities and resources to take the most appropriate decisions, and their involvement in developing the process. In addition, the specific circumstances of each woman and partner such as multiculturality and disability which require specific care, should be considered.

The information provided for women and their partners as a tool to help take decisions should be based on documented evidence and good practices on the efficacy, benefits and risks of existing options which are offered. It should be appropriate in each case and respect the right to know the truth about the health process. Finally, it should ensure that it is understood by means of institutional mechanisms which serve to support effective communication and participation.

Having correct information also ensures the capacity to question and observe the information contained in the different media from a critical viewpoint with the purpose of discerning what is based on authentic technical criteria and that based on commercial interests. This also enables ruling out advice or actions not supported by scientific evidence or common sense.

The work-related rights of women and partners should be recognised and favoured so that both can experience the process in a satisfactory way and combine personal, family and working life for childrearing along with joint responsibility of the partner. Restricting the working rights of women may hinder their physical or emotional recovery and appropriate care of the nutritional needs of breastfeeding babies. Assessing the improvement of these rights is a guarantee to promote the full health of the baby and both members of the couple from a broad bio-psychosocial viewpoint.

Participation of women

The participation of women users in taking decisions is considered in the EAPN as one of its strategic lines. Guaranteed by scientific evidence, the

principal role played by women is notable. This philosophy is extended to the process of pregnancy, puerperium and care of newborns.

The ENSSR upholds this priority as a transversal strategic line for the entire process and considers the need to offer women appropriate information and expert companionship by professionals from the onset of pregnancy which facilitate the active participation of women. Empower them to develop the capacity to recognise the evolution of the process, to have an opinion, discuss with professionals seeing them their care, favour making appropriate decisions after understanding the information and options, contribute to increasing their security and generating a more egalitarian relationship based on the knowledge and expectations of both parties.

In addition, information should be offered on the organisation and resources of the department and procedures established in its protocols as users who participate together with professionals in decisions feel more satisfied with the care received and with the results obtained. Joint responsibility in decisions in practice entails more respect for the preferences of users and more assessment of the professional role. During the consensus and making of joint decisions, options are clarified and beliefs, values, fears and experiences are set out which constitute a bond of mutual respect and recognition in the user-professional relationship which is based on an increased level of satisfaction of users and a reduction in the number of legal claims and reports.

Currently, a large portion of the population is aware of the importance of respecting the physiology of health processes and there is a growing group of informed women and partners who value personalised, intimate and quality care.

Aim:

To encourage the woman to be the protagonist throughout the process and potentiate her capacity for resistance to facilitate the physiological progress and her decision making.

Recommendations:

1. Facilitate women mobilising all their resources, their life wishes, their drive and the satisfaction of experiencing the process.
2. Provide full, appropriate, suitable and comprehensible information to women from the onset of pregnancy.
3. Encourage women to set out their experience, values, expectations, experiences and fears. Ensure communication between professionals

and users and their families and offer information considering each case and needs.

4. Establish prenatal preparation programmes which inform about the physiological changes during pregnancy which consider the emotional and cognitive aspects, incorporating didactic and participatory strategies in addition to psychophysical training. In addition to providing information they should promote the active involvement and participation of women. They should also consider individual and couple, not just group activities.
5. Ensure that pregnant women feel supported, understand the indication, risk and results of tests and procedures in addition to not needing to perform them.
6. Respect decisions made by women and the care they wish to receive in the framework of security and quality of the Strategy.
7. Recognise and guarantee the mother's right on any decision in relation to their newborn and request their consent.
8. Talk about positive experiences of non-medicalised processes and deliveries (videos, testimonials from women, etc.).
9. Promote the inclusion of users' representatives on delivery and breastfeeding committees from hospitals and/or health areas.
10. Encourage recommended support or self-help groups in health centres or areas.
11. Collaborate with non-profit social organisations who work with the same aims considered in this document and which can channel their contributions by means of the Technical Committee for the Strategy.
12. Disseminate the ENSSR for the population's general knowledge and, especially, women of fertile age and their partners.
13. Facilitate simple and quick access to psychosocial professionals for women in vulnerable situations (women alone, adolescents or in situations of social risk).

Participation of partners

The major changes Spain has undergone in the last few years highlight freedom and equality in interpersonal relationships as basic principles and declaration of equality between men and women in all areas of life. This has changed from a marriage based on the authority of men and dependence of

women to a union with equal rights for both people. The fact that men and women are effectively equal as to rights and obligations entails a transformation in family relationships and a fundamental change in their lives.

Parents and/or partners may be overlooked when talking about the well-being of families as if this depended only on women. Current society recognises the need to support and recognise the role of the father and/or partner during gestation, birth and childrearing.

The presence of the father or partner, their care and emotional attention is a necessity for their children and is recognised as one of the factors which reinforces a satisfactory, healthy and happy childhood. Making this a reality depends significantly on social organisation, work regulations and political measures to make this possible.

Recent social changes, promoted principally by women with their incorporation into the outside world and work outside home, the reduction in the number of children and majority access to university have, in parallel, questioned the traditional role of men to construct the ideological concepts and basis of current masculinity.

During these processes age-old certainties are abandoned and uncertainties and insecurities appear along the way to construct a new role based on equality of rights in a balanced distribution of responsibilities, and the attitude to contribute to care and make emotions and feelings visible. This is a model in transition whose paradigm is another more egalitarian one which balances both the benefits and efforts of paternity with those of maternity.

In this context, although work continues to be the centre of men's lives and the basis on which they build their life, their relationships and their bonds and put this way, it is an obstacle to have domestic and family responsibilities, paternity is starting to take on a new dimension. Just as women seek areas in their social life, new possibilities for men open up for their protagonism within the family and at home. The new forms of being a father originate from the transformation of women.

Interiorising paternity represents a complex process which involves a change in values in relation to own identity. Paternity currently represents a profound change regarding the paternal models of the traditional family.

The concept of current paternity abandons the traditional role of the absent father (without proximity or tenderness) and claims a model in which there is more protagonism of children in the life of parents, as a need for mutual relationship and in harmony and reciprocity with the mother/partner.

The positive effects of the involvement of the father which are reflected in evidence on the health and development of children should be considered and encouraged from the start of pregnancy, during the entire antenatal period (maternal monitoring and education), during birth and continuing throughout the entire childrearing process. Strengthening of the father's involvement should continue to be one of the principal lines to improve during perinatal care in our health systems because of the significant consequences on the health of their partner, pregnancy and their baby, not in replacement of the maternal figure but as a complement for joint participation in the process, from the capacities, biological conditioning of the personal, work and social choices of each one.

Aims:

Facilitate the participation of partners from the onset of pregnancy, during the birth and puerperium so that they can be involved and perform appropriate companionship for women at each stage, offering the psychological, emotional and physical support inherent to joint responsibility.

Promote equality of responsibilities between the mother and father in all areas that both can carry out, developing actions which make men capable for child-rearing tasks.

Recommendations:

1. Promote the participation of partners in prenatal preparation programmes so that they have information on the physical, psychological and emotional changes in the women and in themselves during pregnancy so that they can give appropriate support; ascertain the role they may have on delivery and birth; and the importance of their support in postnatal care and joint responsibility during childrearing.
2. Inform the partner about the specific needs of each woman during companionship and the emotional support during the process.
3. Promote personalised communication so that fathers/partners can express their fears, insecurities and expectations.
4. Set up formal channels for participation of partners throughout the entire process.
5. Reveal positive experiences and examples to follow (videos, testimonials, …)
6. Disseminate the Strategy in social and citizen organisations and in specific groups.

7. Advise the father/parent to stop smoking or not to smoke in front of the woman and at home to improve the health of the mother or the newborn and his own health. Note the situation considered as a major opportunity to stop smoking and improve family health.
8. Ensure that the entire family setting adopts dietary habits defined as appropriate for gestation to avoid work overload in preparing different menus.
9. Protect the woman's necessary rest, facilitating a family routine which ensures sufficient hours of sleep at night and/or periods of sleep and rest during the day for pregnant women.
10. Avoid consuming alcohol or other toxic substances at home and during the joint social life to avoid the woman having a desire to consume.
11. Avoid the risk of sexually transmitted infections for the pregnant woman and take the appropriate measures.
12. Effectively share daily tasks avoiding pregnant women or women in the puerperium being overloaded with tasks and thereby facilitating having the necessary rest.
13. Identify the specific needs of the man/partner regarding the process of pregnancy, birth and fertility in general.
14. Involve the partner in family planning programmes and consultations as fathers who wished for the pregnancy are more likely to participate in these.
15. Promote joint responsibility within the domestic setting to facilitate rest and recovery of women following the birth of their babies.

Care of the multicultural

Aims:

Ensure appropriate care for immigrant women and their partners in the process facilitating their participation, considering the characteristics of each case and taking the appropriate measures to minimise possible cultural and language barriers.

Recommendations:

1. Facilitate from primary care everything necessary for a quick incorporation into follow-up of the pregnancy given that health care is universal and guaranteed by law to women from the onset of pregnancy to the puerperium and for infants.
2. Offer specific care according to the different needs of women because of their culture, language, different capacity, beliefs or prior experiences.
3. Have care protocols available which define the necessary actions in these groups of women avoiding taking measures which may mean discrimination. Rather than generating special resources, this will involve normalising quality care because as users are in general well looked after, immigrants will be looked after as well.
4. Facilitate explanatory materials (videos, leaflets, pictograms, etc.) in the different languages to facilitate communication and ensure comprehension of what is happening. Consider other possible resources such as simultaneous translation and cultural mediation.
5. Potentiate communication helping to develop empathy and listening skills which facilitate more well-being for users and health personnel, increasing the capacity to take informed decisions.
6. Improve the information and knowledge of specific pathologies according to countries of origin.
7. Assume the need to guarantee effective rights of access to health care and education of minors and foreign pregnant women regardless of their origin and administrative situation together with compliance with prevailing legislation (OL/96).
8. Pay attention to possible signs of gender_based violence in the same way as highlighted in the general section for care of pregnancy in this Strategy.

Care of the disabled

Aims:

Ensure suitable care for disabled women. Offer the structural means and necessary information which enable exercising their right to freely and responsibly decide the number of children they wish to have, the time gap between them and the satisfactory way to carry this out.

Facilitate the participation of women with disability and their partners during the process considering their circumstances, characteristics, desires and expectations and have the appropriate means and information accessible in each case.

Recommendations:

1. Facilitate accessibility in general, eliminating architectonic barriers, belongings, information and organisation.
2. Have care protocols adjusted to the different disabilities which define the necessary actions in the different situations, avoiding unjustified interventionism and actions which may mean discrimination.
3. Potentiate in particular the resistance capacity of disabled women highlighting their strengths, skills and progress and offer the necessary support for more vulnerable aspects with empathy, quality listening and trust in their hidden capacity underneath their dysfunction.
4. Design specific sexual and reproductive health programmes which consider various needs based on different kinds of disability, including guaranteeing the autonomy of women in decision making regarding voluntary abortion.
5. Potentiate communication between women with disability and health personnel from the viewpoint of considering users and destroying stereotypes, myths and prejudices.
6. Promote actions to increase the autonomy of disabled women in the family setting to avoid overprotection and, in turn, promote participation of the partner and family support during household tasks and the necessary care according to each case.
7. Create information points between disabled women who wish to be mothers and those who already are mothers. Support the presence of mutual help groups by means of women's or disabled associations.
8. Develop programmes together with social services for the provision of services and specific support for disabled mothers during breastfeeding.

3.3.11. Institutional coordination

To help the NHS meets new challenges and provide continuity and compliance with the agreements of the Conference of Presidents held in

September 2005, on this occasion the Quality Plan for the NHS was tackled and this Strategy was developed as an opportunity to implement aims and recommendations which enable guaranteeing quality health care throughout the entire reproductive process, equity regardless of place of residence which is translated into improved health and satisfaction indicators for users.

Offering quality services both for health promotion and health care requires the collaboration of different authorities and institutions and therefore requires the coordination and involvement of different public administrations and sectors in the various fields.

Institutional coordination has the purpose of providing quality care and promotion of reproductive health in which a correct management of human and material resources manifested by means of effective, accessible and transparent services appropriate to needs is carried out. Therefore, work in network may be facilitated which makes possible a quick dialogue between the different institutions and people involved in a same service or between different programmes which need to be complemented or coordinated.

Institutional coordination is a fundamental aspect to perform investigations, implements innovative processes in addition to knowing and sharing good practices between the different autonomous administrations, institutions and also between professionals.

The situation as to existing coordination mechanisms in Autonomous Communities shows major variability and it seems necessary to increase the connection between primary and specialised care teams in addition to collective actions (clinical sessions, periodic meetings) with the support of management.

It is also important to collaborate with other public institutions outside the health field (education, social services, women) and with related social and women's organisations interested in this topic as a means of information for the population and to ascertain their expectations.

Aims:

Project quality reproductive health care with continuity between the different levels of the NHS in which different sectors, institutions and administrations participate jointly.

Potentiate the organisation and management of health resources to implement recommendations on reproductive health for this strategy within the NHS.

Recommendations:

1. Promote the coordination of different care devices and levels of care in their overall management to guarantee equity of access for care of women and their families.

2. Incorporate the recommendations of this Strategy into the portfolio of maternal-child care services for each care entity specifically considering care during pregnancy, the delivery, birth, puerperium and neonatal period and establish the necessary resources and investments.

3. Guarantee the incorporation and adaptation of clinical protocols and guides in accordance with the recommendations from the Strategy and promote their periodic update.

4. Establish the mechanisms which enable full knowledge of this Strategy by the professionals involved in addition to guaranteeing the necessary resources for training and provision of these to attain their aims.

5. Establish coordination mechanisms which facilitate communication and actions between the different institutions and administrations related to reproductive health.

6. Create channels of transversal coordination to incorporate education into promotion and care of reproductive health in the different areas involved such as primary, secondary and university education; social services; health; culture; communication media; legal services; civil society and scientific societies.

7. Encourage the co-operation, integration and participation of all public administrations, institutions and public and private organisations involved in the development, implantation and assessment of this strategy.

8. Strengthen institutional, professional and sectoral coordination by means of participation in the IC and TC for the Strategy, at the same time as potentiating the representation role of people comprising them and facilitating their task in meetings to attend and by means of self work in network.

9. Prioritise the unification of clinical criteria and practices in care of the reproductive process. This necessarily involves continuous communication and perfect coordination between different professionals seeing the pregnant woman or during the puerperium and their family (nurses, midwives, family doctors, casualty physicians, obstetricians, nursing

assistants, hospital orderlies, administrative personnel...) and between the hospital departments with decentralised primary or specialised care.

10. Promote the most effective communication by means of the preparation of written communication protocols, clinical practice and on the transfer of care between the different clinical departments and health professionals in addition to creating committees to support the strategy in which all the professional sectors involved and all the health sectors in the country are represented.

3.3.12. Research, innovation and good practices

Research into all aspects related to care of the reproductive process is considered necessary especially for those in which there is no sufficient evidence, there is controversy and more information is necessary. Research fills in the existing cognitive gaps and contributes to supporting a theory, reformulating it or considering another alternative, proposals which, scientifically backed, may be the fundamental basis to define a determined public policy.

Research highlights the path to follow by which public policies should be based to formulate the possibilities to tackle reproductive health problems of our society and construct proposals for action.

In our society with major changes and constant transformations, the form of organisation defines and frames services made available to citizens such as those aimed at reproductive health. Therefore, research has a fundamental task which is knowledge of the social processes and changes which may affect the care of women, infants and families.

Review of the scientific evidence and pre-existing practices performed for the theoretical basis of this Strategy, detects the difficulty and imbalance to perform neonatology and paediatric studies because of, among other reasons, the few cases and bioethics aspects of research on infants. Knowledge gaps are also detected on active/passive handling of childbirth, different alternative methods to pain during childbirth and positions of the woman, adapting the number of caesarean deliveries and causes of their variability, the administration of supplements or nutrients, screening for streptococcus B, the identification of gender_based violence in pregnant women and the key aspects to empowering women in relation to gender analysis.

The most qualitative aspects of the research to improve the care of the reproductive process become especially relevant considering the different

requirements when based on their physical, intellectual and sensory capacities in relation to their different cultures, customs and emotions. All of this considers the viewpoint of an integrated gender approach.

In addition, scientific research is a fundamental aspect to innovation as it enables constant questioning and review of the way to carry out and the current situation of a determined discipline.

Studies and assessments on the processes, collection of information and systematisation of results are fundamental aspects to generate innovative proposals which help to improve actions implemented from a determined public policy. The NHS may promote care and promotion of reproductive health from improving pre-existing services in addition to driving forward the creation of other new services which adapt to the needs of society. While for this we need to have mechanisms to detect good practices which help to collect and systematise relevant and successful experiences which may be extrapolated to other contexts.

Therefore, it is important as an institutional learning model, to ascertain the experiences of health centres which carry out examples of innovation and good practices during care of normal childbirth. Its dissemination will enable the transfer of knowledge and replication in other centres in addition to its use for teaching.

To identify existing good practices, we need to systematically and transparently collect information on clinical practices and explanatory, training, promotion and prevention actions carried out.

This strategic line of research, innovation and good practices corresponds and continues with the one established as a priority by the EAPN within the NHS.

Aims:

Promote research to improve the quality and warmth of care during pregnancy, childbirth, puerperium and neonatal period, incorporating innovative practices with proven efficacy.

Potentiate the identification of good practices, mechanisms for communication and their dissemination within the NHS.

Recommendations:

1. Facilitate research into care of the reproductive process offered in the health services of the NHS.

2. Support studies on aspects in which there are gaps or less available knowledge.
3. Promote qualitative and quantitative studies aimed at women and their partners to ascertain their opinion, needs and degree of satisfaction with the care received.
4. Facilitate studies aimed at ascertaining the difficulties of professionals who take part in care of the reproductive process to incorporate the scientific evidence into their clinical practice.
5. Promote studies on the physiological aspects of the reproductive process and its psycho-social components.
6. Potentiate research comparing the possible benefits and risks of different existing interventions and non-intervention based on respect and care of the physiological process.
7. Encourage studies to assess the most innovative practices to relieve pain.
8. Promote impact studies of the different practices on the physical and psycho-emotional health of mothers, children and fathers.
9. Prepare clinical practice guides as commonly used instruments for the NHS.
10. Include reproductive health recommendations from this Strategy in calls for research.
11. Identify good practices in care of pregnancy, childbirth, puerperium and neonatal care, analysing the processes of innovation applied and their results.
12. Set up a system to collect, analyse, communicate and disseminate good practices for general knowledge and their possible replication by professionals in different areas.

4. Follow up and assessment of the National Strategy for Sexual and Reproductive Health

The process of follow up and assessment of the ENSSR will start once this Strategy has been approved by the CISNS. To develop this, two Follow up and Assessment Committees comprised of Sexual and Reproductive Health IC and TC will be set up; these will be coordinated by the MSPS's Women's Health Observatory.

One of the functions of these new Follow up and Assessment Committees will be to update the content of the document based on the new evidence available. Another, directly related to this process, will be the review, update and assessment of the ENSSR, which will be performed two years from its implementation and subsequently every four years.

The assessment process to be faced by the Strategy will be complex as first, it aims to tackle the state of the physical, emotional, mental and social well being of men and women related to sexuality and reproduction (and not a specific disease or a set of health problems), and secondly, proposes to collect information on care offered within NHS health services. Therefore, and to facilitate its development, this will be performed over three phases related to the structure, design and results arising from implantation of the Strategy, complying with the following functions:

- **On perfectioning or improvement**, that is, the assessment will enable feedback and learning about the policy acting in turn as a quality guarantee for the assessment. In the specific case of this Strategy, the assessment will be very useful at the three health intervention levels: local, autonomous and state.
- **On rendering accounts and responsibilities**, inherent to the current democratic system where the assessment should serve as an instrument which enables, at the different levels of responsibility, rendering accounts on the management and results of sexual and reproductive health policies carried out by the MSPS and Autonomous Communities.
- **On broadening perspectives** as, although the assessment methodology presented will be delimited by a determined context, situation and moment, it will give us the opportunity to obtain systematic information which may contribute to more overall knowledge.

- **On encouraging equality between men and women** considering inequalities and relationships of power between the sexes and social conditioning factors which hinder or limit the full participation of women in different areas of their life. Taking this into consideration, it may contribute to the reduction of sex inequalities and drive forward the incorporation of egalitarian relationships.

The general aim of the assessment will be to contribute to ascertaining how to tackle care of sexual and reproductive health from health services and strengthen the process to improve this. Later, the Assessment Committees will agree on the remaining operational aims in addition to the questions, criteria and assessment indicators.

It is important to hold present, that the difficulty when obtaining homogeneous information on Autonomous Communities is still a reality. Consequently, the process of assessment will have the added value of driving forward between Autonomous Communities, the collection of information on sexual and reproductive health in a consensual and systematic way.

The development of the assessment will consider quantitative and qualitative methodological aspects in addition to the use of primary and secondary data, which will be developed during the implementation of the assessment process, guided by the aforementioned aspects of structure, design and results.

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When possible, in addition to the surnames, the names of the men and women who signed the works covered in the bibliography, have been incorporated. We have therefore acknowledged their contributions.

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List of acronyms

ACOG	American Congress of Obstetricians and Gynecologists
AE	Atención Especializada
AF	Ácido Fólico
AMPA´s	Asociaciones de madres y padres
AP	Atención Primaria
BVS	Biblioteca Virtual en Salud
CA	Comunidad Autónoma
CCAA	Comunidades Autónomas
CCII	Comités Institucionales
CCTT	Comités Técnicos
CEA	Ciudades con Estatuto de Autonomía
CEDAW	Convención para la Eliminación de todas las formas de Discriminación contra la Mujer
CERMI	Comité Español de Representantes de Minusválidos
CI	Comité Institucional
CIMTM	Comisión para la Investigación de Malos Tratos a Mujeres
CIS	Centro de Investigaciones Sociológicas
CISNS	Consejo Interterritorial del Sistema Nacional de Salud
CJAS	Centros Jóvenes de Anticoncepción y Sexualidad
CMBD	Conjunto Mínimo Básico de Datos
CMV	Citomegalovirus
COF	Centros Orientación Familiar
CT	Comité Técnico
EAPN	Estrategia de Atención al Parto Normal
EASP	Escuela Andaluza de Salud Pública
EG	Edad gestacional
EHRN	Enfermedad Hemorrágica del Recién Nacido/a
ENS	Encuesta Nacional de Salud

ENSS	Encuesta Nacional de Salud Sexual
ENSSR	Estrategia Nacional de Salud Sexual y Reproductiva
EPEN	El Parto es Nuestro
FAME	Federación de Asociaciones de Matronas de España
FPFE	Federación de Planificación Familiar Estatal
GIE	Grupo de Interés Español en población, desarrollo y salud reproductiva
HBsAg	Antígeno de superficie de la hepatitis B
IHAN	Iniciativa para la Humanización de la Asistencia al Nacimiento y la Lactancia
IM	intramuscular
IMC	Índice de Masa Corporal
IME	Índice Médico Español
INE	Instituto Nacional de Estadística
INGESA	Instituto Nacional de Gestión Sanitaria
ITS	Infección de Transmisión Sexual
IV	intravenosa
IVE´s	Interrupciones voluntarias de embarazo
LGTB	Lesbianas, gays, transexuales y bisexuales
LM	Lactancia Materna
MSC	Ministerio de Sanidad y Consumo. Actualmente Ministerio de Sanidad y Política Social (MSPS)
MSPS	Ministerio de Sanidad y Política Social
NICE	National Institute for Health and Clinical Excellence
OEAT	Otoemisiones Evocadas Transitorias
OMS	Organización Mundial de la Salud
OPS	Organización Panamericana de la Salud
OSM	Observatorio de Salud de las Mujeres
PEATCa	Potenciales Evocados Auditivos automáticos
PUBMED	Public Medline
RCOG	Royal College of Obstetricians and Gynecologists

RN	Recién nacido/a
SCIELO	Scientific Electronic Library on Line
SEC	Sociedad Española de Contracepción
SEGO	Sociedad Española de Ginecología y Obstetricia
SEMFYC	Sociedad Española de Medicina de Familia y Comunitaria
SESPAS	Sociedad Española de Salud Pública y Administración Sanitaria
SNS	Sistema Nacional de Salud
SOG	Sobrecarga oral de glucosa
TEPT	Trastorno de estrés postraumático
UCIN	Unidades de cuidados intensivos neonatales
VCE	Versión cefálica externa
VHB	Virus hepatitis B
VZV	Varicella Zoster Virus
WAS	World Association for Sexology
WOK	Web of Knowledge

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