THE NEW EUROPEAN STRATEGY FOR SEXUAL AND REPRODUCTIVE HEALTH: WHY IS SEXUAL HEALTH A PRIORITY THIS TIME?

The time was 1993… we were sitting in the office of as it was then called ‘SFP’ - Sexuality and Family Planning, and discussing with Dr. Daniel Pierotti, the second SFP Adviser since the start of the UNFPA-funded Technical Support Services (TSS) to streamline reproductive health into the agendas of the WHO, Ministries of Health and other organizations dealing with health or development.

It was a young programme for the European Region, as the main focus of TSS had been on those regions of the world with high population growth rates, with subsequently high fertility rates and high maternal mortality rates. The introduction of family planning programmes, there, had two purposes: 1) to contribute to sustainable development and the reduction of poverty by limiting population growth and 2) to contribute to better maternal health and the reduction of maternal mortality by ensuring birth spacing through making good quality contraceptives and counselling services available at affordable prices.

The situation in Europe, in 1993-1994, was very different. The growth of the population was not the problem, on the contrary, most countries, both in western and eastern Europe, were struggling with maintaining replacement level fertility rates and were therefore politically not interested in couples using contraception and limiting the number of births per couple to one or two children. In many countries, notably, for example, in Romania of Ceaucescu, a pro-natalist agenda prevailed, partly based on the fear that not enough young people were in the job market to feed the growing number of old-age pensioners and partly also based on the concern that immigrant groups from poorer countries would have higher fertility rates and thus change the ethnic distribution and make-up of a country.

This political agenda however, did not match the personal situations of many families and couples, who found themselves hit by the economic crisis and radical socio-economic transition their countries were going through, with growing unemployment rates and scarcity of goods and services. Families felt that they could not afford to have more than one or at most two children and limited their birth rates accordingly after the desired family size had been reached. As contraceptives were either unavailable or unaffordable, or people believed that hormonal contraception had many harmful side-effects, this resulted in a high number of repeated abortions used as a method of family planning. Due to the general scarcity of resources in health services at the time the abortion equipment used was often outdated or unsafe. A high proportion of the maternal deaths in the central and eastern European Region and in the former Soviet Union countries were due to abortions performed with such equipment and in an unsafe manner.

On the other hand, planned and desired pregnancies, too, did not always result in safe pregnancies, or safe births, as the scarcity and poor quality of equipment, along with the lack of updated medical expertise resulted in the late recognition of risk factors and respective referral and sometimes risky obstetric practices. The results were unnecessarily high levels of preventable maternal deaths and maternal morbidity, but also preterm births, low birth weight and neonatal and infant deaths at a much higher level than in the western or European Union countries.

Faced with these challenges, the focus of our WHO-UNFPA programmes and projects was to improve reproductive health, to make pregnancy safe, to avoid undesired pregnancies by improving pre-pregnancy, pregnancy, obstetric, neonatal and early paediatric care, as well as increasing the responsibility of men and fathers in the protection of reproductive health (see Image 1).

In the country-wide joint programmes run at the time in Portugal (an exception to the rule in western Europe, where relatively high levels of fertility and maternal mortality still prevailed, particularly in poor regions of the country), in Albania, in Romania and in Turkey, the focus of programmes was on upgrading the knowledge and skills of health providers, upgrading the equipment of hospitals and maternity wards and providing expendable health supplies, drugs and contraceptives.

The focus was very much on maintaining safe pregnancies and helping couples to choose the timing and number of their children, as was also later stated in the Action Plan of the International Conference on Population and Development in Cairo in 1994. Part of this included also preventing, and providing treatment for infertility and understanding its causes. Studies were funded looking at the damaging effects of toxic substances used in industry and agriculture, particularly on male fertility, and discussions started on whether in-vitro fertilization services should be provided for with public funds, as that was also included in the right to have children or not.

We looked at what we called the life-cycle approach to sexual and reproductive health, as we called it at the time, but in reality, it was a life-cycle approach to reproductive health more exclusively (see Image 2).
We included chronic ill health linked to reproductive functions, such as cancers of the reproductive tract and anaemia caused by multiple pregnancies. We included the needs of special groups, migrants, the elderly, the young, promoted the opening of adolescent counselling clinics and of peer education. It was the time of the beginning of the HIV/AIDS epidemic in Europe, but talking about sexual health was difficult politically. Even in the professional context, the discussion on sexual-venereal diseases were confined to a small and well defined medical specialty, dermato-venerology, outside that, there was no space for the professional public health debate on sexual health.

It was also a cultural challenge, as promoting knowledge on sexual health in schools was seen as spoiling young people and ostracizing parents, as if talking about sex and prevention made young people more sex without taking preventive precautions. The education system was reluctant to address the issue and preferred to talk about “Healthy Life-styles” rather than “Sex Education”.

In several countries of the Region, there were conservative streams opposing the sexual health discussion either on the grounds of religion, or on the grounds of tradition. In some countries, abortion was illegal and the use of contraception discouraged. The purpose of sexual relations was seen to be procreation, beyond that, they were not to exist. These kind of legal restrictions ended up leading to travel across borders for abortions or for procurement of contraceptives, sometimes with the consequence of legal prosecution. It took a long time to recognize that these kind of policies were dangerous and detrimental to women’s health and for legal reforms to take place. Another area difficult to speak about in the public health debate was the area of same-sex relations. Human rights movements on the one hand and the imperative of the HIV/AIDS epidemic on the other opened up these previously closed chapters.

Despite all these constraints, the first European Sexual and Reproductive Health Strategy produced in 2001 became, through repeated pan-European expert consultations, a comprehensive document with a framework of objectives, activities and indicators, used by many countries in the subsequent reviews of their own national frameworks. However, it never became a Regional Committee document, as, at the time, the whole area of sexual and reproductive health was considered less important than topics like health financing, primary health care, chronic diseases or child health, all of which were of course less politically controversial and therefore easier to tackle.

Even without a Regional Committee resolution, the implementation of the Sexual and Reproductive Health Strategy over the past nearly 15 years has lead to improved information and public knowledge on sexual and reproductive health, a change of many outdated medical practices, an updating of medical knowledge and an improvement of medical equipment with the help of resources from other organizations, such as the Global Fund for AIDS, TB and Malaria, the World Bank, UNICEF, UNFPA and others. All of this together has resulted in a reduction of maternal mortality and morbidity and of infant and neonatal mortality. Greater attention was also paid to the reproductive health needs of migrants and of young people and to the reproductive health needs of men, and generally, a greater openness in debate, and, at least in some countries, to increased public investments into reproductive health facilities and commodities. The strategy addressed all areas of sexual and reproductive ill health potentially occurring at different stages of life, as represented in the graph (see Image 3).

However, many challenges remain, in particular with regard to the “S” in SRH- sexual health. The first challenge is to demystify sexual health and sexuality to what it is – a part of human nature, human health and human well-being. The need for protection of sexual health starts long before the initiation of sexual activity- it starts with instilling in girls and boys an understanding and acceptance of their bodies and a self-confident approach to sexuality as an integral part of human life and of growing up. That is the responsibility of the education sector and of parents, after which comes the responsibility of the health sector to prevent sexual ill health and to treat it if it occurs. The increasing mobility of society, civil unrest and violence contributing to the HIV/AIDS epidemic and the spread of other sexually transmitted infections, including those leading to the development of cancers of the reproductive tract, as well as the changing of traditions and models of partnership and the generally earlier sexual maturation and sexual debut all call for public health action and increased resources for sexual health and well-being. The development of the new sexual and reproductive health strategy will hopefully provide a new framework and guidance on where investments, be they financial or technical, are most cost-effective and beneficial in the protection of sexual health.