THE LIFE-COURSE APPROACH IN SEXUAL AND REPRODUCTIVE HEALTH (SRH)

“Successful improvement of health at key life stages requires a continuum of interventions across the life-course, combined with efforts to strengthen health delivery systems and address the broader social and economic determinants of health.”

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A life-course approach to health

The WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” (http://who.int/about/definition/en/print.html) Therefore, the WHO is concerned not only with reducing mortality and morbidity but also, and increasingly so in the last few decades, with addressing the impact of health determinants, such as the environmental, economic and social conditions, on people’s health and well-being at various stages of their life.

The significance of the life-course as a framework in health and healthcare is often downplayed as ‘common sense’ and its promotion ‘needless.’ “In reality though, acceptance of this principle has enormous implications on the way an individual’s health is considered, for the training of healthcare professionals and on the manner health systems are developed to cater optimally for the health needs of individuals” (1).

The WHO Regional Office for Europe is fully embracing the life-course approach to health and has made “investing in health through a life-course approach and empowering people” one of four priority areas for policy action in its Health 2020 policy (2). Key stages in people’s lives have particular relevance for their health. The life-course approach is about recognizing the importance of these stages. In the European Region four areas are receiving particular attention, namely maternal and newborn health, child and adolescent health, SRH and healthy ageing (3).

Challenges in implementing a life-course approach to health

The theoretical framework of the life-course approach to health, including SRH, is increasingly supported by sound evidence and is a rational and common-sense approach (4). However, in the real world, applying the life-course approach to the development and implementation of proven interventions that improve health and well-being and prevent poor outcomes is not so straightforward or simple. Factors that contribute to the challenge of operationalizing the life-course approach include, but are not limited to, the following:

1. Both genetic and environmental factors, including the socio-economic environment, influence, shape and affect models of health and illness throughout varying stages of the life-course. Yet, currently we are limited in our ability to alter these potential inter-generational genetic determinants. Furthermore, due to the need for cross-sectoral collaboration both within and across government and broader society, the wider issue of socio-economic inequalities is often ignored as it is felt to be too complex to address easily.

2. Historically, governments have not always taken a long-term vision or approach when it comes to funding and investing resources. Far too often the emphasis has been on immediate, easily tangible results. This is counter-intuitive to the life-course approach, which in the long term provides greater dividends and results but requires that investments be made and maintained with a long-term vision and framework in mind. Moreover, the results of these investments will, in most instances, not be tangible in the short or even medium term. Adopting this long-term vision will require a shift in political thinking and expectations, a change that is not easily accomplished.

3. In many countries, the healthcare system is fragmented and weakened and functions suboptimally. This far too often translates into difficulty providing essential care and services to those in need, especially during critical periods of transitions throughout the life course, such as adolescence or the ageing population.

4. The need for a holistic approach, which is implicit in the life-course concept, is not adequately reflected in the way healthcare providers are trained, healthcare systems are organized and healthcare is delivered.

5. Regrettably, international development initiatives (and the priorities of donor and recipient countries) frequently stand in the way of the life-course approach to health by provoking, wittingly or unwittingly, fragmentation of healthcare delivery. For instance, the focus on family planning during many decades has led to the setting-up, in several countries, of free-standing family planning clinics separate from other services for women’s health. In some countries, this emphasis on family planning has even led to the establishment of ministries for population and family planning separate from ministries of health. Similarly, the unfortunate dichotomy between maternal and newborn healthcare that has hampered making progress on neonatal and infant health, has not been helped by separating maternal and reproductive health (Goal 5) and child health (Goal 4) in the Millennium Development Goals (MDGs). In the Sustainable Development Goals (SDGs) that have been adopted by the United Nations General Assembly on 25 September 2015, Goal 3 (Ensure healthy lives and promote well-being for all at all ages) brings together targets on maternal, newborn and child mortality and on universal access to SRH services including family planning (5). This arrangement resolves some of the fragmentation that existed in the MDGs. However, the fact that Goal 3 of the SDGs has no less than nine targets and all of the
SDGs together have 169 targets with an initial total of over 300 proposed indicators (!!!), puts into question the attention that SRH, including maternal and newborn health, will receive in the post-2015 development agenda.

6. Several areas in SRH concern sensitive matters, such as sexuality and access to safe abortion, and hence a number of governments are reluctant to adopt rights-based progressive policies in these areas.

7. Last but not least, the life-course approach to health is more about prevention than it is about treatment and much of its success therefore depends on people themselves - on the interest they have in, and the care they take for, their own health and well-being. To be able to do this, people must be given appropriate tools; education about health matters starting at a young age, is one, and perhaps the most important, such tool. Regrettably, in the area of SRH, far too many societies are still taking the view that sexuality education for young people is inappropriate.

The continuum of care and the life-course approach

In the critical area of SRH, the emphasis has been predominantly on maternal and newborn health, specifically the physical health of women during pregnancy and delivery and their health and that of their newborn in the first few weeks thereafter. A core principle that has been advocated by the WHO to improve maternal, newborn and child health (MNCH) is the adoption of a “continuum of care” approach by programmes and policy makers (6). This approach has 2 features. To begin with, such an approach means essential MNCH care must be provided “vertically” from the individual household, to the community to the health facilities (see Figure 1). Secondly, it means that care also needs to be provided in a life-course approach throughout the various stages of life (i.e. pre-pregnancy, pregnancy, the neonatal period, infancy and childhood, adolescence, and into the post-reproductive stage) in a continuous and seamless manner (see Figure 2). Such a comprehensive life-course approach, combined with strengthening of health delivery systems to provide universal health care, would contribute much to improving health outcomes at both the individual and population levels, but to date few if any countries have been able to achieve this ideal.

It is now well recognized that the environment in utero, interacting with genetic predisposition, can have long-term effects on the physiology of the foetus and its risk for disease in later life. For instance, maternal health and nutritional status before and during pregnancy and the presence of stress and use of illicit drugs, alcohol and tobacco during pregnancy...
can lead to adverse pregnancy outcomes (i.e. intrauterine growth restriction, prematurity, stillbirth) and affect foetal and early brain development. A poor start to life is associated with an increased risk for several disorders, especially noncommunicable diseases, later in life (known as the Developmental Origins of Health and Disease concept). These disorders include cardiovascular disease, obesity, type 2 diabetes and metabolic disturbances, osteoporosis, chronic obstructive lung disease, some forms of cancer and mental illnesses. Timely interventions may reduce this risk for the individual and also limit its transmission to the next generation, hence the importance of quality pre-conception information and services and pregnancy care for all women, particularly those from disadvantaged backgrounds who are more likely to be malnourished or suffering from mental health or substance-abuse problems.

The school years represent another critical phase in the SRH life-course since it is then that age-appropriate, comprehensive sex education will influence later risk-taking behaviours that could result in unplanned pregnancy or the acquisition of a sexually transmitted infection (STI).

During adolescence, further opportunities exist for policies to affect key events, such as the minimum age of marriage to ensure that girls (and boys) are physically and psychologically prepared for pregnancy and parenthood when they marry or enter into other forms of long-term relationships. Youth-friendly programmes have been shown to be important in influencing the onset of sexual debut, the timely initiation of contraception to prevent unplanned pregnancy and the adoption of measures to protect against STIs. Such programmes also have the potential to prevent gender-based violence against women and girls.

In contrast to MNCH, far less attention has been paid, except in richer societies, to other aspects of SRH which can have an inherent life-course constituent, such as infertility which frequently results from an infectious insult to the reproductive tract at a younger age (for instance, a STI or unsafe abortion), genital and other cancers and the long-term sequelae of giving birth such as genital prolapse and faecal and/or urinary incontinence. Also, the area of male reproduction and that of mental health disorders associated with sexuality and reproduction are often given little or no attention.

Assessing progress towards better sexual and reproductive health

In 2006, the WHO published a list of 17 reproductive health indicators to contribute towards the consistent global monitoring and evaluation of SRH services and outcomes (8). The list was subsequently modified and some new indicators proposed following the adoption of “Achieving universal access to reproductive health [services] by 2015” as a second Target 5b under MDG 5 (9). Monitoring these targets and indicators and implementing the necessary policies and programmes for achieving them would go a long way towards realizing a comprehensive life-course approach.

However, many countries appear to have failed so far to put in place critical SRH policies and programmes and, equally disconcerting, either do not monitor or do not report their monitoring results to international agencies, such as the United Nations or the WHO.

Figure 3 shows a few examples of SRH policies and the attention given to them by the 53 countries of the European Region (10). As shown in the Figure, only 40-50% of countries in the Region have programmes/measures in place to increase access to SRH services, to increase access to SRH services by youth and to improve access to safe abortion services. Twenty to twenty five percent of countries have no affirmative policies in these three areas. With respect to prevention of maternal mortality less than a quarter of countries consider this a national priority but this probably reflects the fact that maternal mortality in the European Region is the lowest among the WHO Regions. Equally as important as the “Yes” and “No” percentages in this figure are the “Not available” percentages (19-34%). This illustrates the need for more complete datasets to enable monitoring of the measures that countries are taking towards implementing critical policies to improve the SRH and well-being of their populations.

The lack of information is equally striking with respect to country reporting of select critical SRH indicators. For instance, the European Health for All database (http://data.euro.who.int/hfad/) has contraceptive prevalence data for only 41 of the 53 Member States of the Region; for 12 of these countries the data are limited to a single data point in the 1990s (11 countries) or the year 2000 (one country).

Figure 3: Selected reproductive health policies in the countries of the European Region (N=53)/10.

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Key interventions and actions

In light of these findings a range of actions can be identified that countries could take towards strengthening the life-course approach to SRH. Some of these include, among others, the following:

1. Establish cross-sectoral collaboration to tackle poor socio-economic conditions. As mentioned earlier, women from poorer segments of the population have a greater probability of adverse pregnancy outcomes and their newborns a higher risk of developing certain diseases in later life.

2. Strengthen healthcare systems both vertically and horizontally. Strong vertical integration between the different tiers of the healthcare system (Figure 1) will ensure that patients have access to the required level of care, for instance when complications arise during pregnancy or delivery or when there is a need for specialist infertility investigation. Efficient horizontal integration between the various healthcare providers and services is essential if patients are to benefit from a holistic approach to their SRH needs at all stages of their lives.

3. Create mechanisms that allow sustainable long-term investments. By their very nature, life-course interventions will rarely yield tangible results in the short term and hence ways need to be found that will ensure that policies and programmes, and the financing they need, do not fall victim to the political whims of changing government priorities.

4. Review, and revise as needed, training curricula of healthcare staff. For staff providing SRH services it would be important, for instance, that training includes recognition of the manifestations of sexual and intimate partner violence.

5. Provide sex education to all school-age children. Although sex education is often discussed and evaluated in terms of its role in reducing adolescent pregnancy and STI rates, its primary goal is broader: to give young people the opportunity to receive information, examine their values and learn relationship skills that will enable them to avoid becoming sexually active before they are ready, to prevent unprotected intercourse and to help young people become responsible, sexually healthy adults.

6. Bridge gaps in services at critical life-course transitions. A prime example of such a gap is the absence of dedicated youth-friendly services. This is often due to the belief that young people should not be sexually active and hence should have no need for SRH information and services. On the contrary, efforts should be made to make available to adolescents, including unmarried ones, the full range of SRH services.

7. Support international and national health promotion efforts that have an impact on SRH outcomes. As mentioned earlier, the mother’s ill-health before and during pregnancy and the use of illicit drugs, alcohol and tobacco during pregnancy creates risks for the foetus both in the short term and in the long term. A comprehensive policy to improve SRH outcomes should also include health-promotion activities aimed at stimulating physical activity and encouraging healthy diets and at preventing being overweight and the use of tobacco and other harmful substances.

8. Strengthen monitoring and evaluation measures. Such measures are essential to ensure that the impact of policies and interventions is documented and shared to the benefit of other countries. Of particular importance is the need to include, in monitoring and evaluation exercises, people from disadvantaged backgrounds, such as those from minority groups, migrants and displaced persons, who may not access regular healthcare and require special, dedicated services. “Only by counting the uncounted can we reach the unreach ed (5).”

9. Support the full spectrum of SRH research. This includes basic, clinical, epidemiological and health systems research, to provide the evidence base for the development of sound policies and programmes.

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References