

International collaboration for sexual and reproductive health

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SUMMARY

Twenty-five years ago, in 1991, family planning services in the UK were under threat due to turmoil in the National Health Service (NHS). However, opportunities were used for proactive intervention. Besides official development assistance, there was substantial involvement of practitioners overseas. Twenty-five years later, in 2016, indicators are being identified for international monitoring of progress in sexual and reproductive health (SRH). This specialty features prominently among the targets for health and gender goals of the 2030 Agenda for Sustainable Development, as adopted at the United Nations (UN) in September 2015, which will guide priorities for international development over the next 15 years.

JOURNAL CHANGES

In 1991, a cursory glance at the contents of this journal could easily have brought to mind the comment by Voltaire that the Holy Roman Empire was neither Holy nor Roman nor an Empire. Despite its title, *The British Journal of Family Planning* was neither limited to a British perspective, nor a journal in the traditional academic sense, nor confined to family planning. With health issues knowing no geographical borders, numerous topics were addressed for their relevance much beyond Britain. Being the journal of the National Association of Family Planning Doctors (NAFPD), it served as its mouthpiece, with columns such as 'Minutes of the Annual General Meeting' and 'From the Clinical and Scientific Advisory Committee', in addition to rubrics entitled 'Meetings and Courses' and 'News and Views' that were a relic of its earlier life as a newsletter. Finally, its contents addressed family planning in the much broader context of SRH. From its humble beginnings as a newsletter, it had undergone major changes to be

"on a sounder financial footing", printed in an A4 format from April 1991 and "The Journal for all interested in reproductive health care" as stated beneath the logo on the cover page.¹

HOLISTIC APPROACH

Whereas NAFPD had spearheaded the initiative for the establishment of a joint faculty with the Royal College of Obstetricians and Gynaecologists and the Royal College of General Practitioners, organisational hurdles were faced unexpectedly after 3 years of discussion due to a policy change of the latter and "difficulties identified by the Privy Council".² This disappointing information was met with great surprise when announced at the Annual General Meeting of NAFPD in April 1991, albeit with hope for a solution during further consideration.

With the NHS being in turmoil, a cost-cutting exercise threatened to fragment and destabilise care by creating autonomous trusts for certain hospital and community units, which would hamper comprehensive planning for the full range of women's services. With the "widespread acknowledgement that family planning is one of a group of services where open, self-referring access to medical care is in the interests of the wider public health", concerns were expressed that "setting up a version of 'passport control' at the reception of our clinics is no way to provide a client-oriented service".³

INTERNATIONAL PERSPECTIVE

Women's wellbeing is best appreciated from vantage points beyond specialty and country. The plight of women is much worse in certain countries due to adverse sociocultural behaviour, harmful traditional practices or deficiencies in health service provision. A poem, from Somalia and addressing feminine pain, reminded readers of potential problems linked to



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sexuality and reproduction such as female genital mutilation, sexual abuse and maternal morbidity. Stating that “the day of circumcision, the wedding night and the birth of a baby are the triple feminine sorrows”, there was an “appeal for love lost, for dreams broken, for the right to live as a whole human being”.⁴

Descriptions by British practitioners of their professional experiences overseas, confirmed that a wider perspective of SRH should supersede the rather blinkered view of providing family planning alone. Working as a medical officer with the Marie Stopes Society of Sierra Leone, an expatriate reported that tasks went much beyond contraception, with the provision of antenatal, gynaecology and venereology services as well as general medical care for men. With secondary infertility due to pelvic sepsis from childbirth, induced abortion or sexually transmitted infection (STI) constituting half of gynaecological consultations, she felt that the associated personal tragedies represented “the ultimate in population control”, which was complemented by breastfeeding by the mother during which “tribal custom decrees that she should not have intercourse”. Certain side effects of contraception need not cause problems, as exemplified by weight gain which was actually sought in view of the sociocultural perception that “obesity is a sign of affluence”.^{5 6}

The annual Ortho Travelling Scholarship, in memory of Dr Ann Horler, provided sponsorship of a NAFPD member to gain valuable experience overseas that would contribute to their daily work subsequently. The 1991 recipient² went to Romania where radical changes in population policies had attracted international attention after the fall of the Ceauşescu regime in 1989. In 1990, Geraldine Howard had died in a car accident “a few days before she was due to visit Romania with a consignment of medicines and other supplies”: she had contributed substantially to services in developing countries with her husband, “the redoubtable paediatrician Hugh Jolly”.⁷ Commodity security is crucial for service delivery⁸ and this need featured prominently in the British population initiative for developing countries as announced in August 1991 and mentioned in the October issue.⁹ Using opportunities to curb population growth, the strategy aimed to address “huge unmet demand for access to family planning advice and supplies” through a three-pronged approach to strengthen reproductive health services, ensure contraceptive supply and promote women’s health and development.

EVIDENCE

Sexual behaviour and practices are sensitive issues, and it was recognised that objective information must be generated from independent research to produce a scientific basis for policymaking. Sex surveys were

discussed at a Wellcome symposium in June 1991 and an account of the proceedings was published in the October issue of the journal.¹⁰ It was agreed that such surveys are crucial to contribute knowledge on fertility, STI and sexual psychology with the production of objective information on behaviour through specially designed studies.

With anticipated changes in the provision of care in Britain, there was “the unknown nature of this ‘new world’, and the current financial difficulties” for health services.³ Despite the introduction of the Körner minimum data set, decision-making for contraceptive care was hampered by paucity of information, especially on process and outcome indicators. Whereas obstetric audit was well established, there was no corresponding framework for preventive community services, and it was acknowledged that the interpretation of indicators of effectiveness of contraceptive services should consider sociodemographic circumstances.

CURRENT IMPLICATIONS

And now, 25 years on, we can celebrate the prominence of SRH in international development, with priority setting during the UN Summit in New York in September 2015 through the adoption of the 2030 Agenda for Sustainable Development, with its 17 Sustainable Development Goals and associated 169 targets.¹¹ Health issues are consolidated under the third goal (SDG3) which aims to “ensure healthy lives and promote well-being for all at all ages”, three of its 13 targets being specific to SRH:

- ▶ Target 3.1: By 2030, reduce the global maternal mortality ratio to less than 70 per 100 000 live births.
- ▶ Target 3.2: By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.
- ▶ Target 3.7: By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Two other targets of SDG3 are very closely linked to SRH:

- ▶ Target 3.3: By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.
- ▶ Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

While the gender goal (SDG5) has targets for reduction of gender-based violence, harmful practices and discrimination, the relevance of sexuality and reproduction to gender was acknowledged through another

target on universal access, which supplements Target 3.7, by addressing reproductive rights:

- Target 5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action, and the outcome documents of their review conferences.

The 2030 Agenda for Sustainable Development is certainly ambitious,¹² and being universally applicable, all countries will need to submit progress reviews biennially.¹³ Policymaking should emphasise equity within universal coverage, resource mobilisation for financing and staff deployment and, finally, good governance for cost-effective service delivery and intersectoral action. The issue of Science, Technology and Innovation, with its unfortunate but widely accepted abbreviation 'STI', is currently the subject of intense consideration for its crucial role as a means of implementation. Consultations are ongoing through the UN Inter-Agency and Expert Group on Sustainable Development Goal Indicators for the finalisation of a proposed set of 230 global indicators, including about 26 for health: they will be supplemented by additional indicators for use at regional and national levels.¹⁴ Their measurement will certainly necessitate the strengthening of national capacities for the prompt reporting of reliable health statistics.

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