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Commentary

In Search of the Third Eye, When the Two Others Are Shamefacedly Shut?

Comment on "Are Sexual and Reproductive Health Policies Designed for All? Vulnerable Groups in Policy Documents of Four European Countries and Their Involvement in Policy Development"

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Abstract
Ivanova et al explored how vulnerable groups and principles of human rights are incorporated into national sexual and reproductive health (SRH) policies in 4 countries. They adapted the EquiFrame of Amin and colleagues of 2011, to SRH vulnerable groups which we believe could now be used for analysis of national SRH polices beyond those 4 countries. Although we fully agree with the authors' two main findings that vulnerable groups and human rights' principles are not sufficiently integrated in SRH policies nor granted the possibility to participate in the process of development in those four countries, we do believe that these shortcomings are not limited to those countries only nor to the identified vulnerable groups either. We are convinced that the issue of SRH as such is still framed within a very limited logic for all with vulnerable groups being perceived as an extra threat or an extra burden.

Keywords: Sexual and Reproductive Health (SRH), Vulnerability, Migrants, Health Promotion, Policies

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The aim of the paper of Ivanova et al[1] was to explore how vulnerable groups and principles of human rights are incorporated into national sexual and reproductive health (SRH) policies of 2 European Member States (Spain and Scotland) and 2 non-European Member States but within the broad European region (Republic of Moldova and Ukraine). The authors analysed SRH policies by applying a very interesting framework. They adapted the EquiFrame framework of Amin and colleagues of 2011,[2] downsizing the 21 core concepts of human rights to 11 and changing the 12 vulnerable groups in order to apply better to the context of sexual and reproductive public health, namely: people living in poverty, in rural areas, the young and elderly, ethnic minorities, asylum seekers, refugees and migrants, people with disabilities, with HIV, with experience of sexual and gender-based violence (SGBV), and finally lesbian, gay, bisexual, transgender (LGBT) and sex workers. They analysed the national SRH policies of these four countries through this framework and then discussed their results with a few policy-makers of the respective countries.

First of all, we do support the authors in their choice of altering the vulnerable groups that were initially identified in the EquiFrame as it is widely evidenced by World Health Organization (WHO)[3] and others that victims of SGBV, LGBT, people with HIV and sex workers are at enhanced risk of ill SRH and regularly mental and physical ill-health as well.[4] Moreover, we would suggest adding migrants with restricted legal status as another category to the EquiFrame, as they face multiple vulnerabilities that are not necessarily the same as ethnic minorities or displaced persons: their utmost vulnerability is linked to the fact of not having a legal status that entitles them to the same access to care, the same opportunity to participate in society and realize their political, social and cultural rights as citizens do.[4]

Secondly, we regret the paper lacks a clear explanation of why those 4 countries were chosen, and how the findings of those countries relate to other countries in the same European region. More importantly, it is a puzzling why the authors only analyzed national SRH policies, as those countries are not standing on their own and many global (eg, United Nations [UN]) and regional (eg, European) policies, directives and legislations also apply to those 4 countries, subsequently framing the national contexts of SRH.[5] Furthermore, SRH is indeed a public health issue that is predominantly framed by policies developed by the Ministries of Health. But the vulnerable groups and human rights principles that are discussed are impacted by many other policy domains that subsequently impact SRH of those vulnerable groups and eventually the entire population. In many countries, Ministries of Equality, Gender, Social Inclusion, Migration, Internal or External Affairs and so forth have very specific stipulations on those vulnerable groups and their SRH. The paper would have provided a more integral view if the authors would have mentioned how several other policies touch upon

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human rights and heavily impact the SRH of many vulnerable groups.

The authors conclude that vulnerable groups are insufficiently addressed in SRH policies of Scotland, Spain, the Republic of Moldova, and Ukraine. This is a worrisome finding as it touches upon a more fundamental question of how European societies deal with SRH as such. While sexual health has long been considered subsumed to reproductive health, the WHO proposed in 2010 to reverse this understanding by stating that *"sexual health requires a positive, respectful approach to sexuality and sexual relationships and that sexuality encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction."*[3] It emphasized the need to "positively" address SRH stressing good health and well-being aspects rather than the absence of diseases and infirmity.[3] Until today, this is not much reflected in general SRH policies throughout the broad European region as the main logic is still focusing on reproductive issues of improving maternal and newborn health. As such this is a goal that can only be applauded but it brings us right at the heart of how European societies deal with SRH of the vulnerable people amongst them.

European societies are ageing and several strategies are developed in order to deal with this. One is focusing on improving elderly people's health and well-being. Whether their sexual health and well-being is also considered is something that can be questioned. Another strategy is a reproductive logic of renewing "the stock" of European native population. Several countries call upon their citizens in reproductive age to have children and stimulate them with all kinds of incentives. To a lesser extent, controlled migration is also considered an opportunity. This is also confirmed in a review of 28 European Member States[5] demonstrating that SRH policies are mainly axed on reproductive health. Yet this review also revealed that the second main emphasis is disease-oriented and intended to prevent disease transmission (for example sexually transmitted infection [STI] transmission) from migrants to the general population. It thus reflects that migration is considered as a public health threat. When it regards migrant victims of SGBV, the same "othering"[6] rationale is applied as it is something that is considered to happen in their countries and or cultures of origin and completely ignores the incidence of victimization that is committed in European societies towards asylum seekers, refugees and undocumented migrants.[7,8]

This is also confirmed in the molding of human rights on migrant health. The European Union (EU) perceives itself as a promotor of human right and all European Member States ratified the "International Bill of Human Rights" which should assure the right to health. The human right to health applies universally and was codified into binding law by the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the International Covenant on Civil and Political Rights (ICCPR) in 1966. In 2000, the UN Committee on Economic, Social and Cultural Rights issued "General Comment 14" stating in paragraph 12 (b) that governments have legal obligations to ensure that *"health facilities, goods and services are accessible to all, especially the most vulnerable of marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds,"*[9] defined as *"race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status"* (§18).[9] In addition, they specified that States have an obligation to respect the right to health *"by refraining from denying or limiting equal access…for all persons."* Yet, the European also adopted its Charter of Fundamental Rights in 2000 which allows for national conditioning for the right to health[5] as it leaves room to different and potentially more restrictive national or subnational provisions which might be inspired by other pressing issues and policies, as migration. Also Ivanova et al[1] came to the conclusion that principles of human rights related to vulnerable groups as mentioned above are rarely included in the SRH policies.

Given this double finding, we can question what this exactly means when a country does not include vulnerable groups in its SRH policies? That those countries prefer that poor people and/or people with disabilities do not reproduce too much as intergenerational transmission might pose huge challenges as well as extensive public health costs? That migrants are only welcome when they bring in young healthy people? That elderly people are stimulated to contributing actively to economy but are considered "asexual" by that age? That young people should be protected from teenage pregnancies but that investing in healthy sexuality and healthy sexual relationships is still very difficult to consider for young people as they too are not considered to be very active yet? That people with HIV and/or victims of sexual violence are mainly perceived as a public health burden that might spill over on other citizens? That LGBT and/or sex workers should not make a lot of noise and should already be pleased that they are tolerated? This all boils down to the fact that many countries in the broad European region still have difficulties with perceiving sexual health and sexuality as positive as well as a human right of all people regardless of gender, age, orientation, legal status, or whatever other ground on which people can be made/become vulnerable.

They apply a very instrumental approach to SRH and have difficulties to promote SRH beyond that approach for everybody, let alone for vulnerable people they often consider as an extra threat or an extra burden. Subsequently, the barriers these vulnerable people might encounter to access SRH care are often neglected. Yet, the General Comment no. 14 clearly specifies that accessibility is core in the right to health[9] and thus a *"legal obligation and not a matter of charity or political choice."* We thus should "get real" and acknowledge, just as the authors of this article, that all people are sexual beings with differing sexual health needs but with the same right to attain the highest attainable standard of sexual health and well-being.

Another finding of the authors is that vulnerable groups in those four countries are rarely enabled to participate in the SRH policies that will apply to them.[10] The Jakarta Declaration on Health Promotion specified that in order to be effective *"people have to be at the centre of health promotion action and decision-making processes"* and that people should be *"enabled to control of those things which determine their health."*[10] Also the EquiFrame stipulates that participation should be foreseen throughout the policy-making process from planning to

evaluation.[11] Yet, we argue again, that this is not only a shortcoming of those four countries, but of most countries in the broad European region. Furthermore it is neither a shortcoming that applies solely to the vulnerable but to most. There are many degrees or modes of participation,[12] but their application currently boils down to categories of providing information over asking contractual and consultative input to collegiate or even auto-regulative decision-making. Most participation modes do not go further than the consultative approach for those who already have or expressed their voice on the matter. For vulnerable people this is even less. This was demonstrated by the European Network for Promotion of Sexual and Reproductive Health promotion of refugees, asylum seekers and undocumented migrants in Europe and beyond that developed a "Framework for the identification of good practices on sexual health promotion in policies and practices"[13] with six core principles, the first 2 being: a rights-based approach and participation. We thus certainly agree with the authors of this paper that vulnerable groups should be included in future SRH policy development but we want to emphasize that quite some tools are already out there to assist policy workers to do so. We thus strongly encourage all stakeholders to drop the blinds and acknowledge that human beings are sexual beings which should be stimulated rather than curtailed.

Ethical issues
Not applicable.

Competing interests
Author declares that she has no competing interests.

Author's contribution
IK is the single author of the paper.

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