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Sexual and reproductive health for all: a call for action

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At the United Nations International Conference on Population and Development in Cairo in 1994, the international community agreed to make reproductive health care universally available no later than 2015. After a 5-year review of progress towards implementation of the Cairo programme of action, that commitment was extended to include sexual, as well as reproductive, health and rights. Although progress has been made towards this commitment, it has fallen a long way short of the original goal. We argue that sexual and reproductive health for all is an achievable goal—if cost-effective interventions are properly scaled up; political commitment is revitalised; and financial resources are mobilised, rationally allocated, and more effectively used. National action will need to be backed up by international action. Sustained effort is needed by governments in developing countries and in the donor community, by inter-governmental organisations, non-governmental organisations, civil society groups, the women's health movement, philanthropic foundations, the private for-profit sector, the health profession, and the research community.

“All countries should strive to make accessible, through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015.”¹

This solemn commitment was made by 179 governments under the umbrella of the UN, at the International Conference on Population and Development (ICPD) in Cairo, September 5–13, 1994.¹ The ICPD programme of action listed in detail the services that should be made accessible for this goal to be achieved. Most countries are

now focusing more attention on sexual and reproductive health than they were 12 years ago, and are working to create better policies and to improve access to information and services.² But progress has been uneven across countries, and across the different components of sexual and reproductive health.^{3–6}

We take stock of the experience of the past 12 years to identify actions needed to accelerate progress. We focus on three areas: the know-how, the political commitment, and the resources to improve sexual and reproductive health for all. We submit that the know-how is available,

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Panel: Key messages

- We have made progress in several developing countries, but we still fall short in many others, particularly in sub-Saharan Africa and South Asia. Yet, sexual and reproductive health for all is still an achievable target. We know the way. We need the will and the allocation of necessary financial resources. Research is needed but should not be used as an excuse for inaction.
- Focus is needed on the modification and building of the basic health-care system, especially in rural areas and in urban slums, which is of particular importance in attempting to meet the millennium development goal of a measurable reduction in maternal mortality ratios.
- To cope with the shortage of human resources for health, physicians should play the responsible part of health-team leaders and be a part of the solution rather than of the problem. Attention should be directed to both the brain drain of physicians and nurses and to the redefinition of the roles of health workers other than physicians and nurses and appropriate training for their expanded responsibilities.
- Non-governmental organisations often can move more quickly and efficiently than governments in uncharted territory and can afford to take risks. Non-governmental and civil society groups, in collaboration with the research community, have a responsibility to criticise the so-called malpractice of basing policies on ideology and not on scientific evidence.
- Integration should be approached in a pragmatic way. Close collaboration between programmes in HIV/AIDS and reproductive health programmes is essential and they should not be allowed to continue to drift apart. And, although HIV prevention must remain a major public-health priority worldwide, family planning and other components of the basic reproductive health package should not be neglected, even in sub-Saharan Africa.
- In sexual and reproductive health, much misinformation and many misconceptions need to be dispelled before issues can find their way to the policy agenda.
- Sexual and reproductive health has not been effectively marketed. Sexual and reproductive health and human rights get good lip service but have lost out in the competition for scarce resources. However, thanks to major NGO advocacy efforts, the Cairo universal access goal now seems likely to be adopted as an explicit target under the MDGs.
- Resources for the sector are not what they should be. Moreover, the US contribution is more than half of total donor assistance and, since it comes with increasingly ideological strings attached, has the effect of denying access to particular cost-effective interventions to important segments of the population.
- The private for-profit sector has a social responsibility within the efforts to accelerate progress towards the goal of reproductive health for all.
- Women's groups and NGOs should take part in when country decisions about budgetary allocations.
- Only 8 years remain until the target date set by the international community for universal access to reproductive health services. Further delays carry a heavy penalty in terms of avoidable human suffering and lost opportunities for economic and human development and for poverty reduction.

but that cost-effective interventions need to be scaled up. Political commitment has drifted or been distracted, and will need to be revitalised. We argue that more financial resources will need to be mobilised, and to be more rationally allocated and more effectively used. Basic health-care systems, especially in rural areas and urban slums, will need to be restructured and built up, as will the health-care workforce. Health-care systems and workers are of particular importance for improvement of the high maternal-mortality ratios in many poor countries, where emergency obstetric care is not readily available. We present the key messages of this paper in a panel.

Scaling-up of cost-effective interventions

Scaling-up health-care interventions could be achieved with a range of approaches, such as expansion of services by replication to serve larger populations; integration of additional services into already existing ones; or efforts to get a particular issue on the policy agenda.⁷ These approaches can be applied to health-care interventions in general, but sexual and reproductive health services have special features.

No one blueprint or magic bullet will achieve sexual and reproductive health for all. Thus we need multifaceted interventions.⁸ For example, in view of the diversity of sexual behaviour, a range of preventive strategies is needed to protect sexual health. The controversy about the ABC (abstinence, be faithful, and use condoms) approach is a sign of the wish to find one intervention that supports particular ideological positions, despite evidence that only a combination of preventive policies will achieve success.

Interventions that are feasible and acceptable in one setting may not work if they are transferred to another situation. Interventions need to be tailored to the local context, since context can determine the best combinations of interventions.³ Scaling-up of interventions has often to be done within the constraints of health systems. For example, we can learn from family planning programmes, that have been successfully adapted to three main delivery systems: health facilities, commercial outlets, and community-based approaches.³ Scaling-up needs to happen despite the shortage of health-care workers.⁹ In most rural settings, appropriate training and use of non-specialist physicians and of health personnel other than physicians is an essential requirement for expansion of the coverage of sexual and reproductive health, as well as most primary and secondary health services. Physicians should take responsibility for leading such teams of health-care workers. The scaling-up of sensitive components in the sexual and reproductive health package calls for partnerships with non-governmental organisations (NGOs), which can move more quickly and less clumsily than governments, and can more easily afford to take risks. In uncharted territory, NGOs can explore and prepare the way for governments to step in.

Although we have the information and means to expand the coverage of quality services, we need to continue to look for more. To achieve universal coverage of services, health-care investigators need, among other things, to develop and test cost-effective interventions that can be implemented and scaled-up in resource-poor settings. However, the need for research should not be used as an excuse for inaction. To ensure that the outcome of the research can be applied, the research community should ensure that their investigations are responsive to real needs, and that they are communicated to where the action is, and where they can have the most effect.

Integration is an effective and pragmatic approach for scaling up of reproductive health services.¹⁰ Because of the close links between the different aspects of sexual and reproductive health, interventions in one sphere will probably have a positive effect in others. WHO's reproductive health strategy¹¹ emphasises that countries should strengthen existing services, and use them as entry points for new interventions. The need for comprehensive sexual and reproductive health care should not be seen as an all or nothing aim. Provision of some services is better than nothing. Services can be built up as resources become available, and according to specific needs and demands. Integration of health-care services should not result in dilution of available resources, but in more effective use of resources. In many countries, early efforts to build vertical delivery systems to address high priority needs have been expanded later by the addition of new services, as and when the systems were capable of expansion and resources became available.

For historical reasons, HIV/AIDS programmes and those for family planning and sexual and reproductive health have evolved separately, and have drifted further apart over the past 5 years. Recent policy announcements¹² call for measures such as: strengthened links between HIV/AIDS and sexual and reproductive health programmes in voluntary counselling and testing; diagnosis and treatment of sexually transmitted infections that increase vulnerability to HIV infection; family planning services to allow HIV-positive people to avoid unwanted pregnancies; and provision of AIDS treatment and care through sexual and reproductive health facilities. Provision of effective contraception to avoid unwanted pregnancies should have equal or greater priority than drug therapy in the prevention of mother-to-child transmission of HIV.¹³ We need to find ways to best link sexual and reproductive health and HIV/AIDS services in different settings.

Another approach to scaling-up health-care interventions is to ensure that sexual and reproductive health issues are on the policy agenda. We need to understand the political context within which service-delivery decisions are made and programmes are delivered.⁴ Evidence of cost-effectiveness is not enough; we need to create a favourable policy environment and to identify and engage key stakeholders. In the sphere of sexual and reproductive

health, misconceptions must often be dispelled before issues can be included in the policy agenda. For example, curriculum-based sex education does not increase risky sexual behaviour as many fear, and trends towards early and premarital sex are neither as pronounced nor as prevalent as some believe.⁸ Neither does making abortion legal, safe, and accessible appreciably increase demand for abortion;⁶ rather, the principal effect is to reduce the number of clandestine and unsafe procedures, in favour of legal, safe abortions. Additionally, emergency treatment of the consequences of unsafe abortions has to be readily available. The population crisis is not over in many countries, and high fertility remains a major dilemma for countries and individuals alike.³ We need to control sexually transmitted infections not only because of their role in fuelling HIV transmission, but also because of the morbidity and mortality that they cause in their own right.⁴

Policy change is not sufficient to achieve an aim—policy must be implemented. For example, legalisation of abortion is a necessary but frequently insufficient step towards improvement of women's health; in some countries, such as India, where abortion has been legal for decades, access to competent care remains severely limited by the scarcity of low-cost services.⁶

Some sexual and reproductive health policies have been adopted in the absence of sufficient evidence, or even in contradiction to the evidence. One example is the widespread promotion of abstinence-only programmes.⁸ Emergency contraception has fallen victim to interest-group manipulation of the evidence, and access remains subject to legal and policy barriers in some countries.¹⁴ NGOs and civil-society groups, in collaboration with the research community, have a responsibility to criticise the malpractice of basing policies on ideology rather than evidence.

Improvement of sexual and reproductive health will need action beyond the health sector. Modification of individual sexual and reproductive behaviour and of social norms is very difficult but indispensable to health. Normative behaviour-change demands a broader definition of public health than is generally accepted.⁸ A high level WHO Commission is working on social determinants in health.¹⁵ Population and family planning policies offer an encouraging example of how mass behaviour can be modified through effective public advocacy and education on the one hand, and accessible services on the other. For example, empowerment of women has a two-way link with sexual and reproductive health. Most women and girls live under conditions that restrict their educational attainment and their economic participation and fail to guarantee them rights and freedoms that are equal to those of men. The empowerment of women through education and employment opportunities is known to be among the most powerful determinants of improved living standards in households, and to be an important



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contributor to national economic advancement. And one of the most effective ways of empowering women is to recognise and enforce their human right of control over their own reproductive systems, enabling them to protect themselves against infection and disease, and against unwanted pregnancies.

Scaling-up of cost-effective interventions will need to be combined with observation and appraisal of their progress. In view of the range of issues covered by sexual and reproductive health, data requirements for review of the effectiveness of interventions are large and diverse. However, since the ICPD, substantial progress has been made towards meeting some of these data needs.¹⁶ The adoption of multifaceted interventions has many implications for what counts as evidence of effectiveness. The broader the scope of the intervention, the less well it can be assessed by rigorous experimental methods, widely regarded as essential to proof-of-effect.⁸ Yet a broad scope is necessary, because interaction and synergy between many components are valued goals for services. Measurement of overall population coverage rates can mask inequities.¹⁷ Importantly, we need to guard against the probability that scaling-up will merely favour better-off groups. Managers, pressed to increase overall population coverage rates quickly, might focus on people who can most easily be reached, rather than the poor and disadvantaged.

Revitalisation of political commitment

Commitment to sexual and reproductive health has been slipping.²⁵ Attention has been distracted by the HIV/AIDS pandemic; new global priorities have emerged in the form of poverty reduction and millennium development goals (MDGs); and the family planning movement has to some degree suffered from its own success. So-called anti-women's rights forces have gathered momentum, and the US administration has worked to roll back many of the agreements reached at Cairo.¹⁸

Marketing of sexual and reproductive health issues has been difficult, and perhaps less effective than it should have been. Although the magnitude of human suffering caused by sexual and reproductive ill health is well established,⁵ such issues have received lip service rather than firm commitment or funding. In the competition for scarce resources, economic arguments tend to carry the most weight. Yet, since Cairo, advocates for sexual and reproductive health have emphasised the human rights case rather than the economic return on investment. In the process, they have lost the interest and support of many finance ministers and donor agencies. Investment in sexual and reproductive health has been shown to pay large economic dividends and this should be again emphasised as a key advocacy position. The benefits of investment in sexual and reproductive health include considerable long-term savings to the health service,^{19,20} and reductions in the direct costs of treatment for complications from abortions.⁶ But sexual and reproductive health is also fundamental to the social and economic development of communities and nations, and is a key component of a more equitable society.⁵

The UN decision to drop the Cairo goal of universal access to reproductive health services from the MDGs^{21,22} has meant that sexual and reproductive health has almost been left out of development priorities at both international and national levels. The UN millennium project report²³ acknowledged this shortcoming, and stated that improvement of sexual and reproductive health is essential for achievement of all MDGs. Thanks to major advocacy efforts by NGOs, the Cairo goal of universal access to sexual and reproductive health now seems likely to be adopted as an explicit target under the MDGs. At the 2005 World Summit review of the MDGs at the UN, world leaders committed themselves to “achieving universal access to reproductive health by 2015, as set out at the ICPD, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration.”²⁴ This global target, with measurable indicators of progress, should go a long way toward re-establishment of sexual and reproductive health as a key priority.

Importantly, the MDGs identified reduction of maternal-mortality ratios for the first time as a key development goal. The difference between maternal-mortality ratios in developed and developing countries is larger than that seen for many other indicators, and is substantially greater than the difference in infant mortality rates. Prioritisation of maternity-care services meets a key human rights goal—namely, that all women have a basic human right to access to maternity care, especially in emergency situations. Since many obstetric complications cannot be predicted or prevented, we need to know that, with appropriate emergency care, most deaths and severe complications, such as obstetric fistula, are preventable. WHO’s 57th World Health

Assembly in May, 2004, also approved a reproductive health strategy to accelerate progress towards the attainment of the MDGs.²⁵ What is now needed is continuous and diligent observation of the implementation of this strategy.

We cannot be complacent. Advocacy effort needs to go further. NGOs are particularly well placed to marshal and present evidence that will convince policymakers not to overlook or shortchange sexual and reproductive health programmes. These organisations are most effective when they work together and speak with one voice. Advocacy at the country level will be most needed, and indigenous NGOs in particular will need support to become effective advocates for sexual and reproductive health.

Resources

Resource flows for sexual and reproductive health are very difficult to assess. In 1994, the ICPD set targets for the mobilisation of resources to achieve its aims. These estimates included family planning and other reproductive health services, such as emergency obstetric care and diagnosis and treatment of sexually transmitted infections and diseases. HIV/AIDS diagnosis, treatment, and care were included, as were basic data collection and research. These estimates totalled US\$17.0 billion in 2000, rising gradually to US\$21.7 by 2015. Nowadays the consensus is that the ICPD’s estimates for HIV/AIDS resources were far too low.

The estimation of actual expenditures is difficult for two reasons. First, many governments, whether in developing countries or donor countries, do not budget or account for expenditures according to the ICPD categories, and thus the proportion of overall health budgets spent on sexual and reproductive health cannot be determined. Second, AIDS-related expenditure has not consistently been separated from overall sexual and reproductive health budgets. Because such spending has ballooned in recent years, it now dwarfs other spending on sexual and reproductive health. Thus, aggregation of the two overstates expenditure on the Cairo Programme of Action, whereas separate accounting has the effect of reinforcing the unfortunate gulf that has grown between the two spheres.

The international community did fall short of achieving the ICPD’s target for 2000—by perhaps as much as 50%. Slow but steady progress since then has brought resource commitments somewhat closer to the 2005 target—thanks largely to the increases in funding for HIV/AIDS programmes over the past 5 years or so.²⁶ But because the ICPD underestimated spending on HIV/AIDS in 1994, resource needs for the basic sexual and reproductive health package will be substantially higher than estimated over a decade ago.²⁷ Funding for HIV/AIDS activities has increased sharply since 1995, from 9% of the sexual and reproductive health total to 56% in 2004. Funding for basic sexual and reproductive health services grew slightly, from 18% to 25%, whereas funding for family

planning services diminished substantially, from 55% to 9% during the same period. In other words, AIDS has almost completely displaced family planning as the programme priority of sexual and reproductive health. Although HIV prevention and AIDS treatment and care should remain public-health priorities worldwide, we should not neglect family planning and other components of the basic sexual and reproductive health package, particularly in sub-Saharan Africa.¹³

Although domestic resource-flows in developing countries account for 73% of the total expenditure on sexual and reproductive health, most of that amount is spent in a few large countries.²⁶ Many countries, especially those in sub-Saharan Africa and others in the least-developed category of countries, cannot generate sufficient resources and still rely heavily on donor assistance. Consumer spending, as measured by out-of-pocket expenditure on health care, contributes the largest share of resources to sexual and reproductive health in developing countries (42% of the total in 2004).²⁴ This fact raises concern about the accessibility of health services to those who cannot afford to pay. Insufficient access to reproductive health services are of particular concern, since in many cases women are the poorest of the poor.

In 2004, donor countries contributed about 5% of their total official development assistance to sexual and reproductive health-related activities, including HIV/AIDS diagnosis, treatment, and care.²⁶ However, this money was provided by only a few donors. The USA alone contributed more than half of the total donor contributions in 2005. Unfortunately, US funding is increasingly linked to ideological policies, which deny funds to some important service providers, restrict services to particular population subgroups (eg, sexually active unmarried young people or men who have sex with men), and restrict use of particular cost-effective interventions. We need to access funds from new donors and to ask existing donors to correct for the identified imbalances. An increasing shortfall in supplies of sexual and reproductive health commodities, including contraceptives and condoms, is also of concern. Demand has been increasing rapidly and neither national expenditure nor donor support have kept pace.²⁸ External assistance complements limited national resources, particularly in poor developing countries, and can also stimulate national action. However, recipient countries are concerned that donors should prioritise the issues addressed in national policies, and donors are concerned about whether programmes can be sustained when they ultimately withdraw funding.

The private for-profit sector has a social responsibility to back efforts towards the goal of sexual and reproductive health for all. Businesses can also profit from the new markets and opportunities that spring from healthy populations. Some of the most promising markets are in developing countries—not only for businesses in the health-care industry, but also for those in other industries,

especially those that have women as major consumers. Within a framework of government leadership, the resources and energies of the private sector can contribute to the goal of sexual and reproductive health for all.²⁹

Developing countries can attempt to mobilise new resources, but should also make the most effective use of existing resources. For example, countries with limited resources can address imbalances in the allocation of resources, such as disparities between urban and rural services, between curative and preventive care, between construction of infrastructure and training of health-care workers, and between different roles of health professionals. Appropriate sexual and reproductive health packages can best be designed and developed at country level. WHO's reproductive health strategy recognises that every country needs to identify and prioritise its own problems, and formulate suitable strategies for accelerated action through consultative processes involving all stakeholders.³¹ Trends in external assistance through sector-wide approaches might not give the necessary emphasis to sexual and reproductive health. A participatory approach is needed, and women's groups and NGOs should have their seats at the table when country decisions about budgetary allocations are made.

Call to action

8 years remain until the target set by the international community for universal access to sexual and reproductive health services. Further delays would carry a heavy penalty in terms of avoidable human suffering and lost opportunities for economic and human development and for poverty reduction. Sexual and reproductive health for all is still an achievable goal. We have access to the information and means to make sexual and reproductive health for all a reality. But do we have the will, financially or politically? Action is a responsibility of all actors, and action is needed now. We call upon governments in developing countries, the donor community, inter-governmental organisations, NGOs, civil society groups, the women's health movement, philanthropic foundations, the private for-profit sector, the health profession, and the research community. Our common future is at stake. With a genuine sustained effort, we can, together, help bring about a brighter future—for women, for families, and for the world as a whole.

Conflict of interest statement

We declare that we have no conflict of interest.

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