Executive Summary of *Lancet* Sexual and Reproductive Health Series

“Reproductive health is a state of complete physical, mental, social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and freedom to decide if, when, and how often to do so.”

*The 1994 International Conference on Population and Development, Programme of Action, §7.2*

Sexual behaviour, family planning, abortion, sexually transmitted infections (STIs), and sexual and reproductive rights are not commonly discussed topics. These subjects often generate strong opinions, make people uncomfortable, and are prone to misinterpretation. So why cover these challenging social and developmental issues in a medical journal?

Worldwide, the burden of disability and premature death due to sexual and reproductive health (SRH) problems is enormous—and growing. Unsafe sex is the second most important cause of morbidity or untimely mortality among the world’s poorest populations, and the ninth most important cause in developed countries. Despite spectacular increases in access to contraceptives globally, more than 120 million couples have an unmet need for modern contraception and an estimated 80 million women have unintended or unwanted pregnancies, with 45 million ending in abortion annually. Pregnancy-related complications kill more than half a million women every year, and leave approximately 210 million women with disabilities, including obstetric fistula. The estimated 135 million women who have undergone female genital mutilation are at risk of obstetric morbidity, stillbirth, and neonatal death. An estimated 340 million new cases of STIs and 5 million new HIV infections occur annually. Violence against women is an underlying risk factor for many of these SRH problems. Women living in violent relationships are often unable to make sexual and reproductive choices and are at greater risk of early and unwanted pregnancy and STIs.

SRH care includes: improving antenatal, perinatal, postpartum and newborn care; providing high quality services for family planning, including fertility services; eliminating unsafe abortion; combating STIs including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting healthy sexuality. At a time of increasing sensitivity among world leaders about SRH issues—and widespread reluctance to talk about them in the context of such political initiatives as the Millennium Development Goals (MDGs)—broad-based advocacy to advance SRH research and programmes is critically needed. It is increasingly recognised that access to SRH services is essential to the provision of integrated care to address HIV/AIDS and to reduce the burden of disease globally.

The *Lancet* Sexual and Reproductive Health Series aims to stimulate awareness and action among decision makers, policymakers, medical researchers and other professionals on emerging and significant SRH issues, while serving as a tool for evidence-based advocacy and
advancing research on preventable illness and death. Due to recent *Lancet* publications on neonatal survival and maternal health and a forthcoming series on HIV/AIDS, these topics are not addressed in this series.

**Cairo and the MDGs**

The 4th International Conference on Population and Development (ICPD) held in Cairo (1994) marked a fundamental shift in attitudes toward population growth—from classical population control and large-scale family planning programmes to a focus on the reproductive and sexual needs and rights of individuals. In Cairo, 179 governments and over 1200 non-governmental organisations adopted the Programme of Action, which established that the promotion of SRH and rights and universal access to services and information on SRH rights are key strategies to achieve the well-being of societies, eradicate poverty, and attain development goals.

In late 2000, the Millennium Declaration and the Millennium Development Goals (MDGs) were adopted by the United Nations General Assembly at its fifty-fifth session, setting the development agenda through 2015. Remarkably, SRH was not explicitly prioritised in the MDGs. Although many SRH and rights themes appear in the MDGs, different components of SRH have been distributed among various MDG goals (ie, maternal health, child health, gender equity, HIV/AIDS) and family planning was excluded altogether, thus, minimising the level of priority that these issues have been given in development and health programmes and financing worldwide. In September 2005, governments redressed this oversight to some degree, recommitting themselves to achieving universal access to reproductive health by 2015 at the World Summit.

Despite advances made at the Cairo conference, the visibility of SRH and rights on the international development and political landscape has decreased over the past 12 years. Between 1995 and 2003, donor support for family planning commodities and service delivery fell from US$560 million to US$460 million. Additionally, funding for contraceptive development has declined, in contrast to HIV/AIDS microbicide research. Analyses conducted for this series, following the UN Millennium Project methodology, suggest that family planning programmes in Africa would cost more than US$270 million in 2006 and nearly US$500 million in 2015 just to reach the medium variant fertility projections of the UN Population Division. Projections of funds from donors ($113 million) and domestic resources ($87 million) fall far short for 2006 needs. Increased donor and domestic funding would save money and lives.

The complexity of SRH creates a challenge for addressing SRH themes such as sex, family planning, abortion, and STIs in development frameworks. Progress in improving SRH at country levels has not been well-documented. Sexual and reproductive rights are not

![Figure: Prevalence of pre-marital sex, percentage of ever-married men and women born 1965-69 who had sexual intercourse before marriage](image-url)
always considered significant by many in health care. As such, in developing and developed countries alike, rights are not always translated into daily practice in terms of privacy, choice, informed consent, confidentiality, and access to the benefits of scientific progress. Furthermore, the increasing influence of conservative forces threatens to undermine progress that has been made before and since ICPD. Despite the profound impact of sexual and reproductive ill-health on individuals and nations, SRH and rights have been neglected and not regarded as a priority in the donor community.

**Sexual behaviour in context**

A public-health lens for examining sexual behaviour is vital to protect individuals from unplanned pregnancy and STIs, and to safeguard their rights to dignity, respect and choice. Information about sexual behaviour is essential to design interventions to improve sexual health and to correct myths in public perception of behaviours. Cross-national comparisons of sexual behaviour (demographic health surveys—DHS) reveal interesting trends in onset of sex, sex and marriage, partnership patterns, risky sexual behaviour, and safer sex. One of the most notable research results is the striking gender difference in sexual behaviour.

Though there are large regional and gender differences in the prevalence of premarital sex, trends towards earlier sexual experience are less marked and less widespread than sometimes supposed (see figure). In most countries, sexual activity begins between ages 15 years and 19 years, with earlier onset for men and later for women. However, the trend towards later marriage has led to an increase in the prevalence of premarital sex. Sexual activity among young single people tends to be sporadic, but is more common in industrialised countries than in developing countries, and is more likely to be unprotected than among older unmarried people.

As a consequence, adolescents have high rates of unintended pregnancy, unsafe abortions, and STIs. In sub-Saharan Africa, 70% of young women become sexually active during adolescence and more than 20% have their first child by age 18 years—often within marriage. Even in countries where contraception is available free of charge, like the United Kingdom, 25% of teenage abortions reflect non-use of contraception, and the rest are the result of incorrect or inconsistent use of less effective methods, such as condoms.

Monogamy is the dominant pattern in most regions, but reporting of multiple partnerships is more common among men than women, and more common in high or middle income than in low income countries. In South America, more men than women report having one or more recent sexual partners in all age cohorts. A recent review of the prevalence of men who have sex with men in 67 studies estimated low lifetime prevalence of sex with men (3–5% in East Asia, 6–12% in S and SE Asia, 6–15% in Eastern Europe, 6–20% in Latin America, 5% in Britain and France).

Married women often find it more difficult than single women to negotiate safer sex, and fewer use condoms for family planning. Negotiation may increase the possibility of physical or sexual violence. In a 10-country study conducted by the World Health Organization on women’s health and violence, 13–61% of ever-married women reported having experienced physical abuse by an intimate partner and 6–59% reported sexual violence. Furthermore, risk factors in male sexual behaviour, such as multiple partners (female and male), directly affect

### Interventions to improve sexual behaviour: lessons learned

- No single, general approach to sexual health promotion will work everywhere. The key is to understand why and how programmes work in particular social contexts.
- Public health interventions need to address the broader determinants of sexual behaviour, such as gender, poverty and mobility, in addition to individual behaviour change.
- Risk reduction messages need to respect diversity and preserve choice. Selective emphasis can have serious downsides. For example, the preoccupation with ABC strategies (Abstinence, Be Faithful, and Use Condoms) distracts attention from the need for broader, integrated programmes in which all components are mutually reinforcing.
- School-based sex education improves awareness of risk and knowledge of risk reduction strategies, increases self-efficacy and intention to practise safer sex, and delays rather than hastens the onset of sexual activity.
- Preventive programmes focusing on naturally occurring social networks have been used to reduce the level of risky behaviour among gay men in Russia; to increase contraceptive use among married women in Bangladesh; and to increase condom use among sex workers in India.
- Strong social prohibitions and sanctions, especially where legislated, may pose the greatest challenges to reduce high risk sexual behaviour.
the health of their wives, who may be monogamous and abstinent until marriage. As such, marriage is no guarantee of safety from HIV and STIs, and may in fact be a risk factor for women.

Factors influencing variations and trends in sexual behaviour are environmental and include shifts in poverty, education and employment; demographic trends such as the changing age structure of populations and the trend towards later marriage; increased migration between and within countries; globalisation of mass media; advances in contraception and access to family planning services; and public health HIV and STI prevention strategies.

Family planning

Family planning is critical to prevent unwanted pregnancies and unsafe abortion and reduce maternal mortality as well as, to reducing poverty, maternal and child mortality; and also empower women to choose when and with whom to have children. Family planning programmes have been remarkably successful in much of Latin America and Asia, including Bangladesh and Nepal. However, in much of Asia the demographic decline has been criticised as coercive. Despite declines in fertility rates over the past 45 years, 26 out of 32 countries analysed in DHS have high rates of unmet need for family planning (20%). In Asia and Latin America, unmet need in the poorest fifth of the population is twice as high as in the wealthiest fifth.

Between 1960 and 2000, the percentage of women using modern contraception globally increased from less than 10% to 60%, and the average number of births per woman fell from six to about three. However, in half of the low and lower-middle income countries (much of sub-Saharan Africa), fertility, population growth, and unmet family planning needs remain high while contraceptive use continues to be low. It is projected that the populations of these countries will double in the coming decades, posing a challenge to achieving the MDGs in much of Africa.

The health benefits of family planning are often overlooked. A significant proportion of abortion-related deaths and obstetric morbidity and mortality could be averted through use of effective contraception to delay or limit childbearing. Additionally, data from national DHS data suggest that one million deaths per year to under-five children are due to inter-birth intervals of less than two years. Effective use of family planning, especially post partum, is one key step toward widening that interval.

Although lower fertility and stable population growth alone will not guarantee achieving the MDGs, their cross-cutting contributions to poverty reduction, better health, enhanced education, and gender equality can have a broad impact. A revitalisation of the development agenda must highlight family planning as a development tool and integrate family planning in the MDG targets. This will require family planning champions from development agencies, bilateral donors, foundations, and NGOs to encourage
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and support the implementation of established population policies in most developing countries. Finally, conservative policies on sensitive issues such as adolescent sexuality and abortion that limit or prevent access to a range of services and technologies must be addressed by the international community through evidence-based advocacy.

Unsafe abortion

WHO estimates that 80 million unplanned pregnancies occur each year. Approximately 26 million of these pregnancies are terminated legally and 20 million through unsafe, non-legal means, primarily in developing countries (97%). Legal abortion in the developed world is a safe procedure with extremely low case-fatality rates of less than 1 death per 100,000 procedures. Manual vacuum aspiration and uterine evacuation, induced through the combined use of mifepristone and misoprostol, are standard WHO-recommended methods that have dramatically reduced complications from abortion. Unsafe abortions, which account for approximately 68,000 deaths and millions of injuries annually, are carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.

Women seek abortions for a variety of reasons for unplanned or unwanted pregnancies. Some women simply are too poor or cannot disrupt employment or schooling to have a child. In other cases, women seek spacing between births or wish to postpone pregnancy. Relationship problems with the husband or partner, as well as risks to maternal or fetal health, may result in a decision for an abortion. Furthermore, some women may wish to terminate a pregnancy arising from rape or incest. In 2000, 101 developing countries did not permit abortion for rape or incest and 65 countries would not permit the procedure to preserve the physical health of the mother.

It is difficult to measure the magnitude of morbidity and mortality related to unsafe abortions, which remains highest in the 82 countries with the most restrictive legislation. It is estimated that over 97% of unsafe abortions take place in the developing world, and over half (55%) occur in Asia.

When abortion is made legal, safe, and accessible, women’s health improves rapidly. In South Africa, for example, the severity of complications resulting from unsafe abortion decreased significantly (16.5% to 9.7%) in the year following the 1996 legalisation of abortion. Although legalisation is a critical step toward eliminating unsafe abortion, it may not translate into broad access to safe services. However, ensuring women’s access to safe abortion services does lower medical costs for health systems. Conversely, restrictive abortion laws translate into a disproportionately high share of abortion-related maternal deaths, even in countries with better access to health care and emergency obstetric care.

Making abortion legal, safe, and accessible does not generally increase demand for abortion, as seen in the case of liberalised abortion laws in Barbados, Canada, Tunisia, and Turkey. Additionally, access to safe contraception can dramatically reduce—but never eliminate—the need for abortion in response to unwanted or unplanned pregnancies.

Unsafe abortion continues to overwhelm health-care facilities in the world’s poorest countries. Often, women with complications due to an incomplete unsafe abortion require medical attention. A population policy that fails to ensure access to safe abortion services and contraception will continue to drive women to seek abortions in unsafe settings. Legal abortion is a universal human right and a critical component of reproductive health services. It is essential to ensure that women have access to safe and legal abortion services in order to achieve the MDGs.

Safe abortion: key components

- Manual vacuum aspiration for surgical evacuation is a standard method within 12 weeks of pregnancy.
- The combined use of mifepristone and misoprostol are indicated for an early medication abortion.
- Prompt and appropriate treatment of complications and timely evacuation of incomplete abortions are critical.
- Post-abortion counselling, education, and family-planning services should be offered promptly.
- Unsafe abortion must be addressed in order to achieve the MDGs.
abortion face discrimination and hostility when seeking treatment for complications and the timely evacuation of incomplete abortions at health-care facilities. Women seeking care for complications should be offered post-abortion counselling, education, and family-planning services promptly.

International rights organisations increasingly regard the denial of safe abortion services and post-abortion care as a human rights violation. The ethical debate regarding abortion will continue, yet it is clear that access to safe, legal abortion improves health and saves lives. As long as women continue to be undervalued, they will suffer and die unnecessarily.

Sexually transmitted infections

Efforts to control STIs are failing, and the health and development impact of STIs is often unrecognised. WHO estimated there were 340 million cases of curable STIs (gonorrhoea, syphilis, chlamydia, and trichomoniasis) in 1999, with 25-7% of these cases in sub-Saharan Africa. An estimated 1-6 million women with syphilis become pregnant annually in sub-Saharan Africa alone, putting themselves at risk for stillbirth or perinatal death. Globally, approximately 20% of women under 24 years have a human papillomavirus (HPV) which causes almost all cervical cancers. More than 25% of the global population over 40 years have been infected with herpes simplex virus-2. Despite these alarming statistics, effective interventions and funding are lacking.

STI control interventions operate on individual, partnership, and population levels. Individual level interventions have been shown to reduce morbidity in single individuals and improve clinical management. However, a gap remains between practice and evidence. Surveillance is often poor and uncertainty exists regarding the transmissibility, duration of the infection, and history of many STIs. Credible estimates from modelling studies are needed on the impact and cost-effectiveness of control interventions among at-risk populations.

Almost all global attention and funding for the area of STIs are directed towards HIV infection, while other STIs receive little attention and are not named in the MDGs. Furthermore, an individual is at greater risk of contracting HIV if he or she is already infected with an STI. Medical and public-health communities need to renew their commitment to control all STIs. Strategies to control STIs need to be tailored to the local or regional epidemiological situation. Integrating sexual and reproductive health services has great potential to reach a wider audience, but may place men at a disadvantage since sexual and reproductive health services are generally aimed at women. Advocacy tools are key in providing clear messages about STI control and getting effective interventions on local and regional policy agendas.
Call for action: recommendations to accelerate progress

Since the Cairo conference, progress in improving SRH and rights at country levels has not been well-documented. However, some successes, as well as many challenges, are evident. Accomplishments include greater attention to SRH and rights at the national level. National DHS data show increased use of key SRH services, such as family planning and skilled attendance at delivery. Furthermore, in developing countries, access to anti-retroviral drugs has increased substantially and a new HPV vaccine has the potential to help prevent one of the primary causes of death among women of reproductive age.

While data is lacking regarding access to some SRH services, such as STIs, post-natal care, abortion and post-abortion care, and counselling and services for youth, access to such services appears not to have increased significantly since the Cairo conference. Geographical access has been identified as a major constraint to access, however evidence shows that women are willing to travel great distances to static facilities. In recent years, quality of care has been acknowledged as a possible barrier to access, resulting in monitoring and evaluation programmes to measure and improve quality of care. In addition, donor fatigue and increased conservatism among some donor countries pose limitations in access to SRH programmes and services worldwide, especially related to sexuality, youth, and abortion. The conservative influence has grave consequences for the well-being of our global population.

Building on lessons learned can contribute to the achievement of the ICPD goals in eight years. The know-how to achieve sexual and reproductive health for all is available. However, cost-effective interventions need to be scaled-up, the political commitment revitalised, and resources mobilised and more effectively utilised.

Scaling-up

There is no magic bullet for addressing SRH problems. Research and discussion on the ABC strategy (abstinence, be faithful, and use condoms) demonstrates however tempting it is to search for a single intervention, evidence shows that multi-faceted interventions are most successful. Such interventions may be scaled-up through the expansion or replication of services, the integration of additional services into already existing ones, or a special effort to get the issue on the policy agenda. Recent policy recommendations have highlighted the need for better integration of reproductive SRH and HIV/AIDS programmes in voluntary counselling and testing, the diagnosis and treatment of STIs that increase vulnerability to HIV infection, family planning services, and the provision of HIV/AIDS care in SRH facilities.

Monitoring and evaluation are key to measure the impact and effectiveness of interventions across a broad array of groups. However, stakeholders have reached limited consensus on a core set of indicators, posing severe methodological challenges. Interventions that have worked in one setting must be adapted to the local context for replication or integration. Human resource constraints must be addressed when scaling-up. Integration of services should result in more effective utilisation of resources. Creating a favourable policy environment and identifying and engaging stakeholders are keys to success. Finally, interventions that address social determinants of health are important in improving SRH.

Revitalising political commitment

Since the Cairo Conference, political commitment to SRH and rights has declined in general while attention and funding has increased for the HIV/AIDS pandemic. SRH advocacy has focused closely on human rights arguments at a time when economic arguments for poverty reduction are critical for development policies and funding. As a result, many donor agencies and governments seem to have lost interest in SRH issues.

The decision to exclude Cairo’s universal access to reproductive health services as a target in the MDGs was a great setback for the SRH field. However, advocacy by the SRH community resulted in a 2005 World Summit commitment to achieving universal access to SRH services by 2015. Furthermore, the recent Millennium Project report entitled Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals acknowledged the SRH and rights are essential for achieving not only the health-related MDGs, but all the MDGs. Advocacy efforts need to be scaled-up, especially at the national level, to convince policymakers of the importance of SRH programmes.
Mobilising resources

The 1994 Cairo conference set targets for the mobilisation of resources for SRH services and programmes. However, funding fell short of the 2000 target of US$17 billion by more than 50%. In the past decade, resources have declined sharply for family planning services. Conversely, HIV/AIDS funding has increased exponentially. While HIV prevention and AIDS care and treatment remain a public-health priority globally, basic SRH family planning services must not be neglected.

Diversification of SRH funding remains a challenge. In 2005, the US government contributed more than half of SRH funding with increasing ideological restrictions on working with certain sub-groups and the use of certain cost-effective interventions. In order to correct this imbalance, it is critical that existing and new donors increase support for SRH programmes and services that have been designed and developed at the country level. Sector-wide approaches to external assistance may not address SRH issues. As such, a participatory, multi-sectoral approach is needed to achieve universal access to SRH services by 2015. Delay brings the penalty of unnecessary human suffering and lost opportunities for economic and human development and poverty reduction.

SRH: whose rights and whose responsibilities?

Sexual and reproductive rights, including the right to choose if, when, and with whom to have children in a safe and secure manner, are integral to human rights. The decreasing commitment to family planning denies human rights and poses economic challenges for the world’s poorest countries. Access to contraception is an important step toward gender equality and in achieving the MDGs. With rights come many responsibilities for individuals, researchers, clinicians, health administrators, academics, religious leaders, donors, and partners, including: (1) the promotion of evidence-based standards of care; (2) a halt in health provider poaching to wealthy countries; (3) education of lawyers, health care providers, and religious leaders in SRH; (4) the removal of conservative barriers to SRH funding; and (5) capacity-building, especially at the community level.

All key stakeholders must take action and responsibility in order to achieve universal access to sexual and reproductive health information, services, and programmes.

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