

## Cairo after 12 years: successes, setbacks, and challenges

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In September, 1994, thousands of policymakers, activists, health specialists, and members of the donor community gathered in Cairo, Egypt, for what turned out to be a unique UN International Conference of Population and Development (ICPD), a true turning point. The Cairo conference put the ideas of comprehensive sexual and reproductive health and rights, choice, women's empowerment, a life-cycle approach, and gender equity at the centre of the international agenda, and signalled the end of the so-called population era. Instead of pursuing demographic targets via family-planning programmes, the goals of the ICPD Programme of Action (signed by 179 countries) were to achieve universal access to safe, affordable, and effective reproductive health care and services, including those for young people, and promoted a gender perspective.<sup>1</sup> The package of services incorporated family planning information and contraceptives, skilled care at pregnancy and childbirth, safe abortion services where and when abortion is legal, and treatment and management of sexually transmitted infections and HIV/AIDS. Governments set a realistic timeframe of 20 years (ie, to 2015), to accomplish the goals established in the Programme of Action.<sup>1</sup>

Where are we now, 12 years after Cairo? What have been the main successes and where have we fallen short? This Comment and other articles in *The Lancet* Sexual and Reproductive Health Series describe achievements and setbacks, as well as the challenges that have been faced for more than a decade.<sup>2,3</sup>

During the past 12 years, commitment to the Cairo Programme of Action has been reaffirmed in several follow-up conferences. But despite the affirmations, the visibility of sexual and reproductive health and rights on the international development and political landscape has decreased. The most obvious evidence of a diminished focus is probably the fact that the Millennium Development Goals (MDGs), which provide the current framework for development efforts, did not include the attainment of sexual and reproductive health and rights as an explicit goal. But the accomplishment of every MDG will be possible only if gender inequities are overcome, and at least three of the eight MDGs are at the core of the Cairo agenda (numbers 4, 5, and 6).<sup>4</sup>

During the past 5 years, this glaring omission has been redressed to some extent. In March, 2005, the fundamental role of sexual and reproductive health and rights in development was highlighted by the UN Secretary-General Kofi Annan in what was probably his most important speech so far about achieving gender equity as part of the MDGs.<sup>5</sup> The UN Millennium Project has since provided concrete recommendations to move the agenda forward.<sup>6</sup> Furthermore, because of the advocacy efforts of national and international non-governmental organisations, universal access to sexual and reproductive health and rights will probably be adopted as an explicit target under the MDGs.<sup>3</sup>

For real change to benefit the sexual and reproductive health and rights of billions of people, it must take place and become sustainable at the national level.<sup>2</sup> Progress in countries has been uneven and, in many cases, not well documented. Among the successes, most nations are giving far more attention to sexual and reproductive health and rights now than 12 years ago, and have been working hard to create better policies and improve access to information and services. Data from demographic health surveys and national health-information systems show some improvement in the use of key services, such as family planning and skilled attendance at delivery.<sup>7</sup> Access to reproductive health services for all individuals through primary health care has not been simple, especially for the most isolated, underserved, and poorest communities.<sup>8</sup> *The Lancet* Sexual and Reproductive Health Series provides an overview with updated information and analysis about

The printed journal  
includes an image merely  
for illustration

specific topics within the broad specialty of sexual and reproductive health.

Why is a straightforward picture of the current status of sexual and reproductive health and rights at the country level so difficult to provide? First, the variety of conditions that prevail in different settings and population groups make summary statements unreliable and unrealistic. Moreover, average figures often hide huge disparities between socioeconomic strata or age cohorts.<sup>9</sup> Second, the comprehensiveness of the agenda for sexual and reproductive health and rights poses serious methodological challenges in terms of monitoring and assessment. Indeed, to measure progress of such a construct needs a large and complex system of indicators. Unfortunately, major stakeholders have achieved only a small consensus on a core set of indicators that have empirical coherence and that can be communicated to the policymakers and financial authorities who allocate resources.<sup>10,11</sup> In fact, no common data system exists to ensure the calculation of indicators at one point in time, and even fewer data are available at many points to show trends. Third, the societal and cultural roots of many sexual and reproductive health problems pose an additional measurement challenge. Fourth, in many cases large-scale national surveys are the only source of data, because routine national health-information systems are weak or non-existent. Finally, in general, we have few data about access to key reproductive health services, such as postnatal care, counselling and services for young people, sexually transmitted infections, abortion, and postabortion care.

What is undeniable is that problems in sexual and reproductive health are still a high priority for developing countries.<sup>12</sup> Why have we not moved forward as effectively and quickly as was expected in 1994? Two closely intertwined factors have contributed to the persistence of these unmet needs: reduced funding and ideological resistance to the sexual and reproductive health and rights paradigm in an increasingly conservative environment.

As Anna Glasier and colleagues describe in the first paper of this Series,<sup>2</sup> sexual and reproductive health, apart from HIV/AIDS, has failed to attract the financial resources that were expected from the donor community, especially in the fields of family planning, unsafe abortion, and sexually transmitted infections. Insufficient international support from donors is often attributed to the incapacity of the

sexual and reproductive health community to sell such a complex concept, and to show in a clear and compelling way that improvement is achievable. Indeed, the ICPD definition is too comprehensive to measure, explain, or communicate easily. The use of this broad model could have diverted attention to the different components of sexual and reproductive health and rights. Moreover, the misperception that the population crisis is over has further reduced resources for family planning, one of the pillars of reproductive health and women's empowerment. Donor fatigue and the financial downturn in the US economy in the early years of this decade have also limited the financial support to sexual and reproductive health.

Resources from developing countries have fallen short. Many of the promised changes have remained at the stage of policy pronouncements and have not reached implementation because of a lack of political will (especially on sensitive issues such as adolescent sexuality and abortion), an absence of financial commitment, little technical expertise, and competing priorities.

Increased conservatism in some donor countries has taken a heavy toll on the efforts to advance the international agenda on sexual and reproductive health and rights. Indeed, contrary to scientific evidence, conservative forces interpret the ICPD Programme of Action's call for information and services for young people as promoting promiscuity and irresponsible behaviour. This misconception has grave consequences for all efforts to encourage the effective and consistent use of condoms and contraceptives in young people. Furthermore, constant attacks by conservative forces on all issues that relate to sexuality and abortion—as discussed in *The Lancet* Sexual and Reproductive Health Series—limit or prevent access to several services and technologies that should be used to improve sexual and reproductive health and rights. This situation exposes millions of women, men, and young people to HIV/AIDS, unwanted pregnancies, and unsafe and illegal abortions.

Despite these challenges, important new technological instruments have been added to the sexual and reproductive health armamentarium over the past 12 years. First, access to antiretroviral drugs has substantially increased in dozens of developing countries. Programmes have been especially effective in preventing the transmission of HIV from infected mothers to fetuses and newborn babies.<sup>13</sup> Second, a safe and effective vaccine against human papillomavirus (and

therefore cervical cancer) was approved by the US Food and Drug Administration only a few months ago.<sup>14</sup> This technology represents a very promising opportunity to prevent one of the primary causes of death in women of reproductive age in developing countries.

In the past 12 years, the sexual and reproductive health and rights community has come a long way: the Cairo model is now a mainstream notion among activists, programmers, policymakers, and academics. We are now more aware of the complex interactions between social, political, cultural, and health factors that shape reproduction and sexuality. We have brought the movements for HIV/AIDS and sexual and reproductive health and rights closer together.<sup>15,16</sup> We know our challenges better, and have more evidence about what works. Indeed, to achieve real impact, a comprehensive approach that improves access to services and their quality, supports functional health systems, community participation, and an enabling environment is mandatory. Renewed efforts building on lessons learned so far and sustained commitment, both internationally and nationally, will contribute to the achievement of the ICPD goals 8 years from now.

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I declare that I have no conflict of interest.

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## XDR tuberculosis: an indicator of public-health negligence

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See [Articles](#) page 1575

In the 1970s, short-course chemotherapy for tuberculosis offered the prospect of eradicating the disease from the world. By the late 1980s, it became clear that the HIV pandemic would lead to a rapid upsurge of tuberculosis in many countries, pose a major threat to tuberculosis control, and destroy the hope for eradication.<sup>1</sup> During the 1990s, multidrug-resistant (MDR) tuberculosis received widespread attention after nosocomial outbreaks in the USA.<sup>2</sup> In today's *Lancet*, Neel Gandhi and colleagues<sup>3</sup> add a new chapter to the story, an outbreak of extensively drug-resistant (XDR) tuberculosis in South Africa, combining the three threats to tuberculosis control: rapid spread, HIV co-infection, and drug resistance.<sup>3</sup>

Gandhi and colleagues' study has important deficiencies, including missing information on resistance profiles to four of the six second-line drug classes<sup>4</sup> and missing clinical data, precluding determination of risk factors for XDR tuberculosis. Nevertheless, the findings show the devastating effect of XDR tuberculosis on patients and health-care workers, its alarmingly high mortality rates in those co-infected with HIV, and rapid nosocomial spread.

XDR and MDR tuberculosis have the same root cause: negligent case-management and poorly functioning public-health services. Acquisition of drug resistance and transmission of drug-resistant strains contribute