

As hospital capacities are increasingly challenged, the mechanisms available to accommodate surges of patients, under normal operating conditions, may be limited. One option is an early warning system for groups that are likely to be affected if access block exceeds critical levels. For example, inpatients' medical services, on activation of the early warning, would be charged with facilitating the discharge of suitable patients, when possible. Personally, I have unpleasant memories, as an admitting officer, of combing through inpatients' medical charts to identify those that could be discharged. Such activities, in effect, amount to reverse triage, albeit without the evidence and sophistication used by Kelen and colleagues.

Hopefully, Kelen's system will rarely need to be implemented. However, we know that smaller surges of patients are frequent, and I suspect that informal reverse triage is also common. Herein lies an opportunity. Could the principles of reverse triage be formally adopted for everyday use? Such a system would need to be evidence-based and founded on acceptable risk tolerance for patients being discharged and for those being admitted. In evaluating the balance between these risks, several factors need to be considered, including the quantifiable risks of access block and premature discharge. However, less tangible endpoints also be taken into account, including the patient's discomfort and inconvenience and staffs' stress and job satisfaction.

In the event of a disaster, a range of risks might need to be tolerated that would otherwise be unacceptable. Hence, if reverse triage systems were to be designed for everyday surges in patients, the cutoffs specified for risk tolerance for consequential medical events would probably be lower than those during disasters. In either scenario, however, it would be unacceptable if reverse triage actually increased the overall risk. I believe that we do not know where the risk balance lies. Indeed, the emerging risks of access block might considerably outweigh the risks inherent in early discharge through reverse triage. This area deserves research. If our communities must accept the risks and



difficulties inherent in access block, we need to consider methods to most effectively distribute and minimise those risks. Reverse triage may provide an opportunity to do so.

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I declare that I have no conflict of interest.

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## Sexual and reproductive health: rights and responsibilities



Sexual intercourse, reproduction, family planning, abortion, sexually transmitted infections, and sexual and reproductive rights are all topics deemed unsuitable for polite conversation at social gatherings; all generate

strong opinion that is often founded in privilege, misinformation, or lack of evidence. The evidence in this *Lancet* Sexual and Reproductive Health Series is not all new and clearly shows the continuing track record of

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preventable deaths and illness in catastrophic numbers that would not be tolerated in most other imaginable situations. Who is responsible? What is the role of sexual and reproductive rights?

Sexual and reproductive rights are an integral component of basic human rights. The fundamental right to health was first codified in the Universal Declaration of Human Rights of the UN General Assembly in 1948.<sup>1</sup> Choice in reproduction was explicitly recognised in 1968 at the World Conference on Human Rights in Tehran, Iran.<sup>2</sup> In Cairo, Egypt, the International Conference on Population and Development (ICPD)<sup>3</sup> in 1994 articulated the need for a human-rights framework to address population and reproductive-health issues to eradicate poverty and improve the quality of life for all people. With agreement from 179 countries, the empowerment of women and achievement of people's individual needs for health, including reproductive health, was accepted as essential for sustainable economic, social, and environmental development. Access to sexual and reproductive health is the gateway to health, because it is pivotal to our survival as a species.

Despite this long history, sexual reproductive rights are not well understood as relevant by many health-care groups—even in high-income countries. These rights are not always translated into daily practice, such as privacy, informed consent, confidentiality, and non-imposition of an individual's religious beliefs onto others. A global illustration can be found in access to sexual assault services as part of sexual reproductive rights, because the

right to benefits of scientific progress includes emergency contraception, antiretroviral drugs (postexposure prophylaxis), use of manual vacuum aspiration, or mifepristone and misoprostol to provide safe abortion services if appropriate. Coerced pregnancy (or abortion) is a violation of the right to liberty and security of the person.

The rights of young people are especially controversial, since their rights to delay marriage until they are no longer defined as children (age 19 years) would reduce the inherent maternal mortality of pregnant young adolescents. But there is already substantial unmet need in comprehensive sex education and services for adolescents, married or not. This sound public-health approach, supported by evidence and implied in a combination of rights treaties, is difficult to implement and dependent on community participation.

The reduction of commitment to family planning is a denial of several rights, and aggravates economic challenges in low-income countries. These include the right to decide freely whether and when to have children, and the right to liberty and security for women, who have the right not to die from pregnancy-related causes. The right to life has been marketed by religious groups with a narrow definition not intended in the scope of international law, but shows how effective the marketing of rights can be. An estimated 90% of deaths from unsafe abortions and 20% of obstetric mortality could be averted by rightful access to effective contraception.<sup>4</sup> In *The Lancet* series on neonatal survival, Lawn and colleagues<sup>5</sup> estimated that 4 million neonatal deaths a year were closely linked to sexual and reproductive health, especially maternal mortality and morbidity. By eliminating interbirth intervals of less than 2 years, the evidence suggests that an additional 1 million deaths a year in children younger than 5 years could also be averted.<sup>4</sup>

Having ratified their commitments to various rights treaties, countries are obligated to implement them and report to monitoring committees on their progress. Because access to contraception represents the most important step towards gender equality, generally recognised to be pivotal in achieving all the Millennium Development Goals, governments can be called to report to the committees for the Convention for the Elimination of Discrimination against Women, the Convention on the Rights of the Child, and the Covenant on Economic Social and Cultural Rights. Health-professional organisations

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and academia can participate in these reporting sessions to present evidence that has been ignored and to increase the profile of the reports, which are rarely seen in the mass media. Increasingly, countries are also being held accountable by the courts to make existing laws (especially those on abortion) transparent, fair, and evidence based, with findings provided by clinician researchers and other professionals.

Responsibilities to implement sexual reproductive health and rights need political will at the national level. The suggestion that individuals should behave more responsibly, or that with rights come responsibilities, assumes that people have the skills and resources at their disposal to behave in that way. We are far from that debate. Researchers have a responsibility to provide the evidence that forms the basis for recommended standards of health care, including new technologies and treatments. Clinicians have a responsibility to practise evidence-based care in the context of their country and to advocate for evidence-based changes or clarity in health policy and law to reduce mortality and morbidity. Health administrators have a responsibility to stop active poaching of health-care providers from resource-poor settings and to think innovatively about basic health-care training. Academics have a responsibility to educate lawyers and health-care providers in sexual reproductive health and rights. Religious leaders have a responsibility to consider how they can support sexual reproductive health and rights, rather than leave a perception of condoning a double standard that has fatal consequences for women and children. Donors and funding governments have a responsibility to remove barriers

to implementation of sexual reproductive health and rights, rather than tying funding to non evidence-based requirements, which includes adequate funding of health-care providers. Collaboration between parties with responsibilities for sexual reproductive health builds capacity, and community participation is of vital importance.

It is not only possible but essential that evidence-based sexual reproductive health and rights and known economic arguments are better used to ramp up the currently unacceptable rate of progress. Denial of sexual and reproductive rights is a preventable cause of death. The causes are power, politics, and poverty. The deadly reluctance to discuss sexual behaviour and related health issues factually must be overcome. This *Lancet* Sexual and Reproductive Health Series offers a catalyst.

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## Sex, politics, and money

Women and girls, men and boys bear an unacceptable burden of sexual and reproductive ill health, and the raw statistics that illustrate this burden are shocking. Women and girls bear the brunt of the load. A quarter of women in developing countries suffer illness, injury, or disability, often hidden, as a result of pregnancy and childbirth. They are denied their sexual and reproductive health rights and subjected to appalling gender inequalities. Neema's story is just one example.<sup>1</sup> Neema is a 17-year-old Tanzanian girl who was raped when she was 15. Her family arranged for her to marry the rapist—in exchange for six cows. Neema

soon became pregnant. After a long, painful labour she had a caesarean section but the baby was stillborn, and she developed a fistula and was leaking urine. Her husband no longer wanted her, but accepted her back after surgery to repair the fistula. He started beating her when he could not immediately resume sexual relations, so Neema ran away. Now she sells vegetables in a market, and sleeps there at night, making her vulnerable to physical and sexual assault.

WHO has estimated that sexual and reproductive ill health accounts for almost 18% of all lost disability-



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