

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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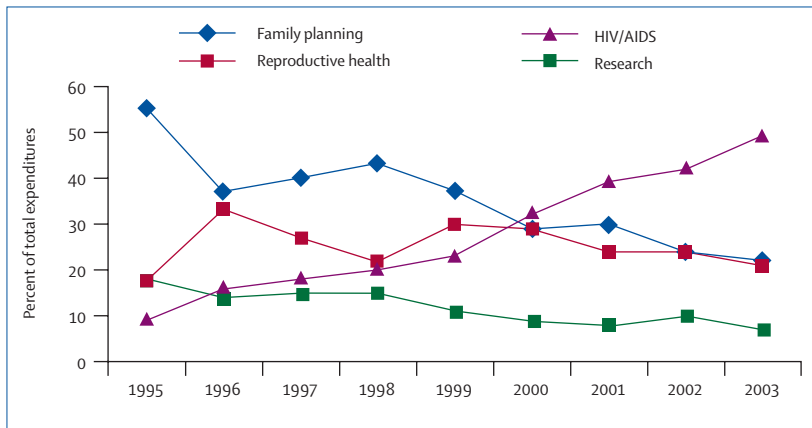


Figure: Resources for family planning and basic service for reproductive health<sup>10</sup>

adjusted life-years (DALYs).<sup>2</sup> For women and girls of reproductive age (15–44 years), these conditions account for nearly a third of DALYs lost. This is an enormous burden of ill health and injustice. Access to services for sexual and reproductive health enables families to plan childbearing and can play a large part in helping to prevent these conditions, including sexually transmitted infections such as HIV.

Improving sexual and reproductive health is also important for national development and economic growth. The populations of many of the poorest countries will double or triple over the next 40–50 years, making it far harder to reduce poverty and keep pace with the necessary investment in basic services, such as health and education.

Why has progress stalled? What should happen now? The papers in this series on sexual and reproductive health give a solid account of many of the issues of health policy and service delivery that must be addressed. There are four more key areas where change is necessary—politics, money, how international aid works, and health systems—if we are to create a world where girls and women like Neema can have better chances in life.

First, since 2000 there has been a resurgence in ideologically based views that hinder constructive international policy dialogue on sexual and reproductive health and rights and HIV prevention. The approach taken by the International Conference on Population and Development is just as valid today as it was in 1994, when 179 governments signed up to the programme of action.<sup>3</sup> The continuing lack of access to reproductive health supplies, such as contraception and drugs to manage delivery complications, is every bit as disturbing as the

lack of access to drugs for AIDS, tuberculosis, and malaria. Some conservative forces sadly do not want to address the difficult issues of sex, sexuality, and adolescents' and women's right to control their fertility. They prefer to see the world only in terms of their own ideology. Such an attitude is pulling us backwards when we need to go forwards.

We should not have to waste time debating the importance of sexual and reproductive rights, or the role of condoms in HIV prevention. Only now, after 6 years of intense and difficult negotiations, do we finally have the prospect of a reproductive health target within the Millennium Development Goals. In a world where an estimated 19 million women every year face an unintended pregnancy,<sup>4</sup> and where there are over 340 million new cases of curable sexually transmitted infections,<sup>5</sup> in addition to around 5 million HIV infections,<sup>6</sup> such delays are difficult to justify.

Strong leadership and progressive policies can make a huge difference. The Government of South Africa reformed the abortion law in 1996 and rapid implementation has resulted in a 91% reduction in deaths due to unsafe abortion.<sup>7</sup> In Thailand, new HIV infections have fallen from 140 000 in 1991 to fewer than 21 000 in 2003, in part by expanding sex workers' access to condoms and to treatment services for sexually transmitted infections, including HIV.<sup>8</sup>

Second, more money is needed. In 2005, the G8 and other donors pledged to provide an extra US\$50 billion a year in aid by 2010.<sup>9</sup> Africa should receive an extra US\$25 billion of this amount a year. But these commitments must be turned into reality and appropriately channelled to improve people's sexual and reproductive health. While international donor funds for HIV activities have increased in recent years, those for family planning and basic reproductive health have declined (figure)<sup>10</sup>—no doubt in part due to international politics and also to the emphasis given to HIV treatment at the expense of prevention.

Providing more money is necessary—but is not enough. The way in which money is provided also influences progress. For example, there is a crisis in ensuring a reliable and sustained supply of crucial supplies for sexual and reproductive health, such as family planning methods, male and female condoms, and equipment to ensure safe abortion and post-abortion care. Work funded by my Department to explore this crisis suggests that

the unpredictable nature of donor funding in this area is resulting in short-term stop-gap measures rather than attention to strengthening the systems and capacities in procurement and logistics that are necessary to sustain supplies in the long term.<sup>11</sup> We urgently need better and more sustained ways of ensuring the required funding for supplies for sexual and reproductive health.

Aid is a means to an end—in this case improved sexual and reproductive health—and the way aid is delivered influences its effectiveness. We need to ensure that money is made available to civil society groups, who are best placed to lobby on behalf of poor and marginalised people, as well as being given to governments.

Third, the global aid system that delivers development aid and technical assistance is highly complex. Many organisations work with the governments of developing countries in uncoordinated and often competitive ways, taking up valuable time and resources. For example, there are concerns that narrowly earmarked and targeted funds for HIV are having an impact on services for sexual and reproductive health. Community-level health workers in Malawi are now specialising in HIV testing,<sup>12</sup> which is important—but does this draw them away from their other core functions? In Kenya and Zambia, clinicians and laboratory workers have left the public sector for better-paid, but often more narrowly focussed, jobs funded through big donors, such as the Global Fund for AIDS, Tuberculosis and Malaria.<sup>13</sup> The global aid system must be simplified to ensure that aid is both efficient and effective.

Finally, but importantly, the health systems that deliver information, services, and supplies in sexual and reproductive health must be strengthened. Health systems in developing countries face many challenges: severe and long-term underfunding; deteriorating infrastructure; unreliable or inadequate supplies of essential drugs; weak institutions and governance; increasing shortages of trained health workers, particularly in under-served rural areas; and weak information systems needed to monitor progress. The problems are huge—some 1 million additional health workers are needed in Africa. Without attention to addressing these challenges, a long-term sustained improvement in services for sexual and reproductive health is unlikely.

However, while we must improve health systems and the supply of services, that is not enough. Factors determining health are often complex, and encompass not only cost and availability of services, but also relate, for

example, to discriminatory behaviour by providers, sex-related barriers, and other cultural and social constraints, such as those experienced by Neema. A broad approach is needed, one that supports the mobilisation of citizens who are knowledgeable about their rights and empowered to demand these from institutions that are obligated to respond. Mechanisms that make the state accountable to its citizens need to be strengthened.

I commend *The Lancet* for taking the initiative to produce this series on sexual and reproductive health, and I hope that, like the previous series on child health, it will reinvigorate efforts to produce action. But, more importantly, I hope the international aid community can realise it is time to put aside differences and recognise that girls and women like Neema do not have the opportunity to engage in ideological debate. They need access to effective basic services and they deserve to have their voices heard and rights respected at every level—within their families, their communities, their parliaments, and within international debate.

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## The future of onchocerciasis control in Africa

The battle against onchocerciasis in Africa has been led by the Onchocerciasis Control Programme in West Africa (OCP, 1974–2002) and the African Programme for Onchocerciasis Control (APOC). Both programmes aim to eliminate onchocerciasis as a disease of public-health importance and as an obstacle to socioeconomic development. Over the long term, as a health and development programme, OCP has achieved its goals in ten of 11 West African countries.<sup>1</sup> Since OCP started in 1974, no child born in the region has gone blind because of onchocerciasis. However, the disease itself has not been eradicated. Some residual infections exist, and persistent in-country conflicts preclude full access to control in some countries. These challenges need attention and active surveillance from national health authorities. Here, we briefly take stock of the effort to combat onchocerciasis in Africa, and present highlights of the Summit of Partners of Onchocerciasis Control, held in Yaoundé, Cameroon, on Sept 26–27, 2006.<sup>2</sup>

APOC was launched in 1995. Within 12–15 years, it seeks to establish sustainable community-directed treatment with ivermectin,<sup>3</sup> to protect more than 102 million people. It is one of the first partnerships established to

control a neglected tropical disease, and operates as a strong and unique grouping of 19 African countries, 20 donor countries and organisations, 12 international non-governmental development organisations (NGDOs), 30 local non-governmental organisations, a private-sector company (Merck), and 117 000 communities. 14 million people received ivermectin in 1997. Currently, via APOC, more than 40 million people receive regular ivermectin treatment through a community drug-distribution mechanism, helping to avert 500 000 disability-adjusted life years (DALYs) a year, at US\$7 a DALY.<sup>4</sup>

In community-directed treatment with ivermectin, the programme has enabled access to onchocerciasis treatment in neglected and hard-to-reach areas in countries during or after conflict. APOC also targets and serves extremely poor populations, helping strengthen national health systems to build local capacity where services are weakest. One reason for OCP/APOC's sustained success has been integration of research within the framework of activities, mainly through the Special Programme for Research and Training in Tropical Diseases. This integration has enabled the programmes to be highly innovative and collaborative in the development, assessment, and use of new instruments and methods, and has led to evidence-based strategies, such as the implementation of community-directed interventions. This integration of research into control will continue in the new strategy.

APOC is planned to close in 2010, but the battle against onchocerciasis has not yet been won. Every effort must be made to ensure that the substantial financial investments in OCP and APOC, drug donations worth more than \$1.5 billion, and the success of the past, are sustained for the future.

In view of such challenges, the meeting in Yaoundé aimed to share and review recommendations from a working group on the strategic overview of the future of onchocerciasis control in Africa.<sup>5</sup> The meeting brought together various partners of APOC and OCP, African Ministers of Health, donor agencies, NGDOs, national onchocerciasis coordinators, representatives from Merck,

### Panel: Yaoundé Declaration on onchocerciasis control in Africa<sup>2</sup>

We, as African Ministers of Health:

Express our commitment to work together to accelerate the elimination of river blindness as a public-health and socioeconomic development problem in all countries

Call for the intensification of control activities and surveillance in postconflict countries and countries with pockets of co-endemicity of onchocerciasis and loiasis (tropical eye worm)

Endorse the conclusions of the working group on the future of APOC and its recommendations to extend the life of APOC to 2015 and enlarge its activities to ex-OCP countries

Recommend strongly that APOC provide a scientific evidence base to determine the steps, the period, and the area where ivermectin treatment could be stopped in close consultation with affected countries

Urge endemic countries to make annual budgetary commitment for onchocerciasis control activities as part of PRSP and in line with MDGs

Declaration signed by following countries: Angola, Benin, Burkina Faso, Burundi, Cameroon, Central African Republic, Chad, Congo Brazzaville, Côte d'Ivoire, Democratic Republic of the Congo, Equatorial Guinea, Ethiopia, Gabon, Ghana, Guinea Bissau, Guinea Conakry, Kenya, Liberia, Malawi, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, Sudan, Tanzania, Togo, and Uganda.