Sex, rights, and politics—from Cairo to Berlin

Sex happens: 125 million times each and every day. So how is it that in the 21st century this precious element of human existence is still taboo? We are used to seeing sexualised images, yet the reality of sex and reproduction seems as secret as ever. In the political and religious skirmish over sex and morality, we often lose sight of the critical contribution that a realistic approach to sexual and reproductive health makes to our lives.

Against this backdrop, we are marking the 15th anniversary of the world's most comprehensive blueprint for sexual and reproductive health. The 1994 International Conference on Population and Development (ICPD) in Cairo was a defining moment that resulted in a visionary plan that placed individual human rights at the heart of global development.[1,2] ICPD saw a consensus around population and development among 179 governments along with unprecedented and diverse participation by civil society.

ICPD was groundbreaking, with the potential to be revolutionary if fully implemented. It upset prevailing orthodoxies and attracted much criticism from religious and political opponents—mainly over reproductive rights. Nevertheless, ICPD brought about a seismic change in thinking about population and development, moving from demographics to sexual and reproductive health and wellbeing with a new emphasis on individual rights and gender equality. ICPD recognised that comprehensive sexual and reproductive health, including voluntary family planning, is essential for individual and national development, as well as being one of the most cost-effective routes for alleviating poverty. More recently, the ICPD goal of "universal access to reproductive health" has been incorporated into Millennium Development Goal (MDG) 5B and its contribution to all of the MDGs has been belatedly acknowledged.

The Programme of Action that emerged from ICPD offered a roadmap for the next 20 years. But 15 years on can we honestly say we have followed that roadmap? This is the question we will be posing when non-governmental organisations (NGOs) meet at a Global NGO Forum on Sexual and Reproductive Health and Development on Sept 2–4 in Berlin, Germany, hosted by the German Government and the United Nations Population Fund (UNFPA).

Although there has been progress, this has been selective and uneven. The right to the highest attainable standard of health, particularly sexual and reproductive health, continues to elude millions of people, especially the poor and marginalised. Statistics speak for themselves. Over 200 million women currently lack access to modern contraceptives, and demand for contraception is expected to increase by 40% by 2050.[3] There are more than 1·5 billion people aged between 10 and 25 years—the largest generation of young people in history—and they will need sexual and reproductive health services.[4] Globally there are about 33 million people living with HIV,[5] with 2·7 million new infections in 2007, most of which are sexually transmitted infections. Every year, more than half a million women die in pregnancy or childbirth, including 67 000 women from unsafe abortion.[6] Millions more suffer injury, illness, or disability.

While ICPD offered a visionary plan, political leadership and financial commitment have been lacking; between 1994 and 2008, funding for reproductive health as a proportion of health aid dropped from 30% to 12%.[7] Led by the conservative US administration of George W Bush and the Vatican, political opposition to ICPD resurfaced and programmes for sexual and reproductive health came under sustained attack at the UN and around the world.[8] At the same time a global HIV epidemic devastated communities, and in the response linkages to sexual and reproductive health and rights were not always fully understood or implemented. Today, these linkages are understood, potentially strengthening the response to both HIV and sexual and reproductive health.

The challenges today are perhaps greater than those faced in 1994. The global financial crisis, the impact of climate change, increasing religious fundamentalism, and fragmented health systems are some of the challenges. That is why this anniversary is so important. By holding governments to their promises of 15 years ago, NGOs can remind them that sexual and reproductive health is a more important long-term investment than arms—a third of countries spend more on the military than they do on health and nearly half of countries with the highest defence spending rank among the lowest in human development.[9]

The Global NGO Forum on Sexual and Reproductive Health and Development will act as a clarion call to reinvigorate the ICPD Programme of Action to make it a reality for all women, men, and young people. We have clear evidence that sexual and reproductive health saves lives and makes a critical contribution to poverty reduction and development. Strengthening sexual and reproductive health and rights is a pressing global need, one on which the future of humankind may well depend.

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We declare that we have no conflicts of interest.

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Elective caesarean sections—risks to the infant

Beena Kamath and colleagues[1] recently reported that, in 2006, 31·1% of births in the USA were by caesarean section. Over 80% of women who have had a first caesarean section will have a repeat operative delivery, because of the fear of scar rupture during normal labour. Although there is concern about this high rate of surgical delivery, a consensus group of the US National Institutes of Health (NIH) in 2006 found no good evidence of harm to the mother from one or even two caesarean sections.[2] However, they did recommend that elective delivery should not be done before 39 weeks of pregnancy because of the risk of respiratory problems in the baby, echoing findings from UK studies.[3,4]

Kamath and colleagues assembled a retrospective cohort of 672 women with one previous caesarean delivery. They compared outcomes in the baby after repeat caesarean section before labour with planned caesarean section after the onset of labour, and after successful and unsuccessful planned vaginal delivery (emergency caesarean section). Babies born by successful planned vaginal delivery had the best outcomes, and those born by emergency caesarean section the worst. Delivery by elective caesarean section was more expensive in terms of costs from the hospital and physician, and the babies had higher rates of admission to the neonatal unit, need for supplemental oxygen, hypoglycaemia, and respiratory problems. Worryingly, despite the NIH recommendations, median gestation at elective caesarean section before labour was 39·1 weeks, indicating that almost 50% of women still delivered too early, presumably for convenience or choice. Those who had emergency caesarean sections (26% of those attempting vaginal birth) had the greatest morbidity, but this finding was largely accounted for by induction of labour and chorioamnionitis, each of which is an independent predictor of adverse outcome for the baby.

The recommendation of Kamath and colleagues that rates of caesarean section should be reduced takes no account of the fact that some women fear a vaginal birth, especially if their first labour (or that of a close friend or relative) was a bad experience that ended in an emergency caesarean section[5] or damage to the pelvic floor. However, in this relatively small sample, there were no cases of catastrophic uterine rupture, the most feared consequence of "trial of scar". Caesarean delivery is often considered an expression of maternal autonomy