Editorial

Reproductive health: widening horizons

J. Patrick Vaughan[1] & Carla AbouZahr[2]

Ever since the concept of reproductive health was put forward at the International Conference on Population and Development (ICPD), held in Cairo in 1994, there has been debate about where its boundaries lie. Clearly, reproductive health is about preventing and treating disease, but it is also about supporting normal functions such as pregnancy and childbirth. It is about reducing the adverse outcomes of pregnancy — including maternal deaths and disabilities, abortion complications, miscarriages, stillbirths and neonatal deaths — but it is also about enabling people to have safe and fulfilling sexual relationships, and to decide if and when to have children. Above all, reproductive health is about life-enhancing processes and how to nurture them in the face of adversities such as gender discrimination, inequity, exploitation, conflict and economic disruption.

Though it does not cover the full spectrum of the new concept, the theme section in this issue of the *Bulletin* presents some of the key components of reproductive health: family planning, abortion, maternal morbidity and mortality, perinatal and neonatal mortality, sexually transmitted infections, and the difficulty of adequately measuring the full dimensions of reproductive ill-health.

Although modern methods of fertility control are now much more widely available in low-income and middle-income countries, health planning is usually based on the assumption that women and men have similar desires about ideal family size. However, Ratcliffe et al. demonstrate from the Gambia (pp. 570–579) that desired fertility can be very different between women and men, even in the same communities within a country. They point out that programmes need to find better ways to work with these diverse views on ideal family size.

Several articles examine interventions for reducing the burden of disease associated with sex and reproduction. For example, Berer emphasizes the need for an open public health perspective on abortion and presents a wide range of experiences from countries that have sought to meet this need (pp. 580–592). In poorer countries, a woman's life-time probability of dying is about 200 times greater than in wealthier ones, as is well documented by the studies of Prual et al. in West Africa (pp. 593–602) and Walraven et al. for the Gambia (pp. 603–613). Graham et al. focus on improving the quality of hospital obstetric care (pp. 614–620) and show how a practical list of indicators for clinical audit were agreed by using consensus methods with health professionals from settings as varied as Ghana, Jamaica and Scotland.

As demonstrated by Dugald Baird over 50 years ago in the United Kingdom and again by Kusiako et al. using surveillance data from Matlab, Bangladesh (pp. 621–627), perinatal and infant mortality are also important outcome indicators for reproductive health and not only for child survival.

A note of caution is sounded by Dehne et al. (pp. 628–639), who warn that the enthusiasm for integrating family planning and the control of sexually transmitted diseases that sprang from the ICPD may be misplaced. A wide review of secondary documentary sources, mainly from donor agencies, suggests there are fewer benefits than had been expected from this approach.

Langer et al. describe ways of dealing with the dual challenge of broadening the reproductive health agenda while promoting health sector reform (pp. 667–676). Country experience shows that the two movements have broadly compatible aims and objectives and that reform also offers opportunities for improving the delivery of reproductive health care.

Two further articles examine issues of measurement and estimating the burden of reproductive ill-health or disease. Sadana points out that despite advances in the policy agenda, sexual and reproductive health lacks clear definitions and rigorous methods for assessment, thereby complicating decision-making about priorities (pp. 640–654).

Given that the DALY methodology for estimating disease burden will be used again for the year 2000, the final paper by AbouZahr & Vaughan offers a critique of its application to reproductive health and makes suggestions on how future DALY estimates could be improved (pp. 655–666).

The Public Health Classic examines the impact of reproductive health on women and on poor groups in society. Dugald Baird in his 1952 Cutter Lecture (*1*) chose to focus on the impact of the prevailing social and economic conditions on pregnancy and perinatal outcomes. Fathalla in his commentary takes up and amplifies this theme (pp. 677–678).

The papers in the theme section of this issue of the *Bulletin* remind us that some important lessons need to be relearnt. First, the poor fare far worse than the rest of society on all reproductive health outcome indicators. But poverty is not an insurmountable barrier to health when there is high level political commitment to investing in health. Second, gender-based discrimination is an important determinant of poor reproductive health. Women suffer the major burden of sexual and reproductive ill-health because they also suffer discrimination in access to basic needs, health services and the exercise of human rights. And third, the intergenerational impact of poor reproductive health needs to be more clearly acknowledged. Investments in reproductive health bring benefits both to the young people and adults of today and to the infants and children of tomorrow. ■

1. **Baird D.** Preventive medicine in obstetrics. *New England Journal of Medicine*, 1952, **246**: 561–568.

[1] Professor of Epidemiology and Public Health, London School of Hygiene and Tropical Medicine, London, England.

[2] Senior Monitoring and Evaluation Adviser, UNAIDS, 1211 Geneva 27, Switzerland. Correspondence should be addressed to this author.

Ref. No. **00-0736**