ICPD25
International Conference on Population and Development

UNFPA

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: AN ESSENTIAL ELEMENT OF UNIVERSAL HEALTH COVERAGE

Background document for the
Nairobi summit on ICPD25 – Accelerating the promise

United Nations Population Fund
November 2019

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: AN ESSENTIAL ELEMENT OF UNIVERSAL HEALTH COVERAGE

Background document for the
Nairobi summit on ICPD25 – Accelerating the promise

ICPD25
International Conference on Population and Development

ACKNOWLEDGEMENTS

This document was commissioned by the United Nations Population Fund (UNFPA) and prepared by Jesper Sundewall and Andrea Hannah Kaiser under the coordination of Anneka Knutsson (UNFPA)

Inputs were provided by Ian Askew (World Health Organization-WHO), Howard Friedman (UN Population Fund-UNFPA), Mikaela Hildebrand (Swedish International Development Cooperation Agency - Sida). Jean-Pierre Monet (UNFPA), Mandira Paul (UNFPA), Petra ten Hoope-Bender (UNFPA), Lale Say (WHO), Ann Starrs (Bill & Melinda Gates foundation) and Jyoti Tewari (UNFPA).

All country examples were reviewed by UNFPA HQ and regional and/or country offices.

Country examples on Nepal, Thailand, Mongolia and Cambodia were developed by the authors.

Country examples on South Africa and Rwanda in collaboration with the Clinton Health Access Initiative.

Country examples on Eastern Europe, West Africa, Ethiopia and Latin America were developed by UNFPA staff.

KEY MESSAGES

- Sexual and reproductive health and rights (SRHR) are an essential part of universal health coverage (UHC). Countries moving towards UHC need to consider how the SRHR needs of their population are met throughout the life course, from infancy and childhood through adolescence and into adulthood and old age.

- To effectively meet the SRHR needs of people, a comprehensive approach to SRHR is required. Taking a comprehensive approach to SRHR entails adopting the full definition of SRHR and providing an essential package of SRHR interventions with a life course approach, applying equity in access, quality of care, without discrimination, and accountability across implementation.

- A comprehensive approach to SRHR is cost-effective and affordable for most countries; however, certain countries will require increased investments to successfully adopt and progressively realize SRHR in UHC. Increased domestic resource mobilization is critical to sustain gains made so far and enable additional investments.

- There are concrete steps that countries can take to advance towards UHC and universal access to quality SRHR interventions. These include mobilizing stakeholders within and beyond the health sector; analysing SRHR needs among all people and throughout the life course; mapping the resources available and systems constraints; and prioritizing and progressively implementing interventions at various levels of the health system and beyond for ensuring access to an essential package of SRHR interventions.

- Several countries have made significant progress in the implementation of SRHR interventions. Examples in this paper illustrate good practices and lessons learned that can inspire and inform countries embarking on SRHR and UHC reform.

CONTENTS

INTRODUCTION

2019 marks the 25th anniversary of the 1994 International Conference on Population and Development (ICPD), where 179 governments agreed that human rights, including reproductive rights, were fundamental to development and population concerns and where a programme of action was adopted that called for all people to have access to comprehensive reproductive health care, including voluntary family planning/contraception and safe pregnancy and childbirth services (United Nations Population Fund, 2014). Many countries have taken great strides to improve sexual and reproductive health by integrating key services in their universal health coverage (UHC) reforms (Sundewall, 2019).

The Nairobi Summit on ICPD25 provides an opportunity to complete the unfinished business of the ICPD programme of action and also a chance to commit to a forward-looking sexual and reproductive health and rights (SRHR) agenda to meet the Sustainable Development Goals (SDGs) and its targets. It is an opportunity for the global community to build on the ICPD framework and fully commit to realizing a visionary agenda for SRHR and to reaching those who have been left behind. This agenda must pay attention to population dynamics and migration patterns, recognize the diverse challenges faced by different countries at various stages of development, and ground policies and programmes in respect for, and fulfilment of, human rights and the dignity of the individual (United Nations Population Fund, 2019).

Since 1994, the world has developed through responding to the Millennium Development Goals (MDGs), which focused on the achievement of a few, specific health targets, to commit to the comprehensive 2030 Agenda for Sustainable Development. The aspirational targets of the health SDG (SDG 3 – Good Health and Well-being) are not merely ambitious in themselves, but cover nearly every important aspect of human well-being, both physical and relational. Unlike the MDGs, the SDGs explicitly recognize sexual and reproductive health as essential to health, development and women's empowerment. Sexual and reproductive health is referenced under both SDG 3, including met family planning needs, maternal health-care access and fertility rates in adolescence, and SDG 5 (gender equality), which additionally refers to sexual health and reproductive rights.

With the SDGs, the world has also committed to achieving UHC, including financial risk protection, access to high-quality essential health-care services and access to safe, effective, high-quality and affordable essential medicines and vaccines for all. In connection with the 74th session of the United Nations General Assembly (2019), world leaders made a political declaration[1] recommitting to achieving UHC by 2030. The declaration further re-emphasizes the right to health for all and a commitment to achieving universal access to sexual and reproductive health services and reproductive rights as stated in the SDGs. As such, UHC and SRHR are intimately linked. Without taking into account a population's SRHR needs, UHC is impossible to achieve, as many of the basic health needs are linked to people's sexual and reproductive health. Similarly, universal access to SRHR cannot be achieved without countries defining a pathway towards UHC, which includes prioritizing resources according to health needs.

The purpose of this paper is to define and describe the key components of a comprehensive, life course approach to SRHR. Furthermore, the ambition is to describe how countries can

1 A/74/RES/2: Political Declaration of the High-level Meeting on Universal Health Coverage "Universal health coverage: moving together to build a healthier world"

move towards universal access to SRHR as an essential part of UHC and to provide inspiring examples from countries that have moved in this direction.

The starting point for this background paper is the internationally agreed commitments to sexual and reproductive health articulated in both the ICPD Programme of Action (United Nations Population Fund, 2014), the World Health Organization (WHO) reproductive health strategy (WHO, 2004) and the Political Declaration of the High-level Meeting on UHC (UN, 2019). The paper further builds on the work presented by the Guttmacher–Lancet Commission on SRHR,[2] which proposed a comprehensive definition of SRHR accompanied by an essential package of SRHR interventions (Starrs and others, 2018). The Guttmacher–Lancet Commission goes beyond the ICPD definition and covers sexual rights and the emerging consensus around the interventions needed to address the SRHR of all individuals. For countries to realize the targets of UHC and universal access to SRHR, adopting a comprehensive approach to SRHR is essential. SRHR are essential to human life and to overall health and well-being over the life course and, therefore, SRHR should be part of public health and development strategies. Investing in SRHR is beneficial to societies because it strengthens families and helps increase prosperity. The most vulnerable and poorest people, with the least access to health care, bear a disproportionate burden of poor sexual and reproductive health. Consequently, a comprehensive approach to SRHR is needed to address gaps in the delivery of SRHR interventions and the political, social, cultural, gender, economic and financial barriers that prevent people from fully achieving their SRHR.

2 The commission was co-led by the Guttmacher Institute, the African Population and Health Research Center and *The Lancet*.

Table 1.

Key SRHR and UHC targets in the SDGs

 3.1	By 2030, **reduce the global maternal mortality ratio** to less than 70 per 100,000 live births
 3.2	By 2030, **end preventable deaths of newborns and children under 5 years of age**, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
 3.3	By 2030, **end the epidemics of AIDS**, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
 3.7	By 2030, **ensure universal access to sexual and reproductive health-care services**, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
 3.8	**Achieve universal health coverage**, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all
 5.2	**Eliminate all forms of violence against all women and girls** in the public and private spheres, including trafficking and sexual and other types of exploitation
 5.3	**Eliminate all harmful practices**, such as child, early and forced marriage and female genital mutilation
 5.6	Ensure **universal access to sexual and reproductive health and reproductive rights** as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences

Unlike the MDGs, the SDGs explicitly recognize sexual and reproductive health as being essential to health, development and women's empowerment.

A COMPREHENSIVE LIFE COURSE APPROACH TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Good sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to sexuality and the reproductive system. All individuals have a right to make decisions governing their body and to access services that support that right (Starrs and others, 2018). Every individual has the right to make his or her own choices about his or her sexual and reproductive health, which implies that people should be able to have a satisfying and safe sex life, the capability to reproduce and the freedom to decide if, when and how often to do so (United Nations Population Fund, 2014; WHO, 2004).

For universal access to SRHR to become a reality, national policies and implementation plans need to take a comprehensive approach to SRHR. Following such an approach will, for a relatively low cost, realize benefits for different populations, including saving lives and improving household income and health. This approach will also contribute to the development of different countries (Starrs and others, 2018).

As illustrated in Figure 1, taking a comprehensive approach to SRHR means that countries adopt the comprehensive definition of SRHR (Starrs and others, 2018); provide a package of essential SRHR interventions in line with the definition; ensure application of the cross-cutting principles of equity in access, quality of care and accountability; and take a life course approach to SRHR when defining needs and providing interventions.

a) A comprehensive definition of sexual and reproductive health and rights

The comprehensive definition of SRHR proposed by the Guttmacher–*Lancet* Commission (Starrs and others, 2018) covers sexual health, sexual rights, reproductive health and reproductive rights[3] and reflects an emerging consensus on the services and interventions needed to address the sexual and reproductive health needs of all individuals. Additionally, it addresses issues such as violence, stigma and respect for bodily autonomy, which profoundly affect individuals' psychological, emotional and social well-being. It further specifically addresses the SRHR of neglected groups (e.g. adolescent girls, LGBTI+[4] individuals and those with disabilities). As such, the definition offers a comprehensive framework to guide governments, United Nations agencies, civil society and other stakeholders involved in designing policies, services and programmes that address all aspects of SRHR effectively and equitably.

3 For a full definition of SRHR see Annex 1.

4 lesbian, gay, bisexual, transgender, intersex and other sexuality, sex and gender people

Figure 1. A comprehensive definition of sexual and reproductive health and rights

Table 2: Proposed essential SRHR interventions as part of a comprehensive approach to SRHR (Starrs and others, 2018)

- Comprehensive sexuality education (in and out of school);
- Counselling and services for a range of modern contraceptives, with a defined minimum number of types of methods;
- Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care;
- Safe abortion services and treatment of the complications of unsafe abortion;
- Prevention and treatment of HIV infection and other STIs;
- Prevention of, detection of, immediate services for and referrals for cases of sexual and gender-based violence;
- Prevention, detection and management of reproductive cancers, especially cervical cancer;
- Information, counselling and services for subfertility and infertility;
- Information, counselling and services for sexual health and well-being.

b) A package of essential sexual and reproductive health and rights interventions

In line with the comprehensive definition described above, a package of essential SRHR interventions has been proposed by the Guttmacher–*Lancet* Commission (Table 2), corresponding to those laid out previously by WHO (2017). Most of these interventions are cheap and cost-effective (Watkins and others, 2017), which makes SRHR interventions, such as reducing unintended pregnancies and unsafe abortions, preventing human immunodeficiency virus (HIV) infection and other sexually transmitted infections (STIs) and providing affordable modern contraceptive methods and sexual health counselling, sustainable at low cost. Therefore, investing in SRHR as part of UHC is a logical investment in both high-resourced and low-resourced settings.

A health intervention is an act performed for, with or on behalf of a person or population whose purpose is to assess, improve, maintain, promote or modify health, functioning or health conditions. As such, the concept of SRHR interventions is somewhat broader than that of SRHR services and needs to go beyond the health system and include other stakeholders and interventions.

c) Cross-cutting principles of equity in access, quality of care and accountability

Paying due attention to three cross-cutting principles, namely *equity in access, quality of care and accountability*, is key to acquiring a comprehensive approach to SRHR and to advancing both the SRHR aspects of Agenda 2030 and UHC reforms, and should be part and parcel of implementing the essential SRHR interventions. These principles impact both the delivery of sexual and reproductive health services and the realization of individuals' sexual and reproductive rights:

- **Equity in access** – Individuals in need of services can access them irrespective of their ability to pay, socioeconomic status, geographic location, ethnicity, education or gender and are empowered to use these services;

- **Quality of care** – Commodities and facilities are of good quality and services are delivered in a safe, effective, timely, efficient, integrated, equitable and people-centred manner, based on care standards and treatment guidelines and taking into account people's experiences and perceptions of care, including affordability and acceptability;

- **Accountability** – SRHR is underpinned by human rights and political, financial and performance accountability, with inclusiveness and transparency at all levels of the health system, and ensuring that rights holders' views and demands are captured and taken into account in planning and implementation.

Equity in access, quality of care and accountability are fundamentally a matter of respecting, protecting and realizing human rights, including the right to health, of all individuals. Fulfilling these three principles and the right to health in all of its forms and at all levels requires services, commodities and facilities to be available in sufficient quantity; to be physically and financially accessible; to be acceptable, that is respect medical ethics; and to be culturally appropriate and responsive to gender and life course requirements. It also means catering for the specific needs of diverse population groups, with respect for confidentiality and informed consent, and that services should be scientifically and medically appropriate and of good quality (WHO, 2017). Accessibility further implies fulfilment of the principal of non-discrimination and the right to seek, receive and impart health-related information (United Nations, 2000; World Health Organization, Office of the United Nations High Commissioner for Human Rights, 2007).

d) Applying a life course approach when implementing essential sexual and reproductive health and rights interventions

A life course approach recognizes that people have different and changing sexual and reproductive health needs throughout their lives, from birth to adolescence, different stages of the reproductive age and old age. The different stages require access to different sets of SRHR interventions. In addition, a life course approach takes account of how sexual and reproductive health needs are met, and how sexual and reproductive rights are realized, at one stage in life and has implications for sexual and reproductive health outcomes and needs during other stages of life. Hence, a life course framework enables an understanding of opportunities to intervene in order to improve health in later life. In addition, it highlights the importance of effective sexual and reproductive health promotive, preventive and curative services that focus on the SRHR needs of individuals in each life stage to reduce the total burden of disease as the population ages.

Some SRHR interventions are particularly important for specific population groups at a certain time in their lives (e.g. antenatal care), whereas others can be critical throughout the life course (e.g. prevention and treatment of HIV infection and other STIs). Additionally, depending on the choices a person makes during their life, SRHR needs look different. For instance, a person choosing not to have children has different SRHR needs from those experiencing pregnancy, and a person acquiring an STI has SRHR needs related to the specific disease. The SRHR interventions offered must therefore be structured to take into account the future SRHR needs that will arise, depending on the choices that people make, the circumstances they are exposed to and their specific life course trajectory. A life course approach to SRHR interventions must also consider the needs of particularly vulnerable groups, such as those with disabilities, adolescents and LGBTI+ individuals, and the implications of legislation around, for example, abortion and age of consent.

If essential SRHR interventions are omitted, this can have implications for how SRHR and other needs change. For example, comprehensive sexuality education (CSE) improves sexual and reproductive health outcomes, resulting in a reduction in the rates of STIs, HIV infection and unintended pregnancy (UNESCO, 2015). Omitting CSE from national plans and strategies will result in negative consequences for the population's sexual and reproductive health, which in turn has implications for health systems and, subsequently, countries' development. These close interlinkages between the essential SRHR interventions reinforce the necessity of taking a comprehensive approach to SRHR, including the package of essential SRHR interventions, and of applying a life course perspective in doing so. Figure 2 illustrates an exemplary selection of SRHR issues experienced during the life course. In addition, it shows how the various components of the package of essential SRHR interventions proposed by the Guttmacher–*Lancet* Commission (See Table 2) relate to the different life stages that individuals go through. As this figure implies, several package components are important over the whole life course (e.g. information and counselling, HIV and AIDS prevention and treatment, and sexual and gender-based violence), whereas certain components relate mainly to a specific life stage (e.g. newborn care, CSE and infertility services). The need for SRHR interventions is generally greatest during an individual's reproductive years (age 15–49 years) and in adulthood (age 20–59 years).

Figure 2. Exemplary illustration of SRHR issues and the components of the essential package of SRHR interventions proposed by the Guttmacher–Lancet Commission for use during the life course

0–9

INFANCY AND CHILDHOOD

Antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care

Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence

Prevention and treatment of HIV and other sexually transmitted infections

10–19

ADOLESCENCE

Comprehensive sexuality education (in and out of school)

Prevention, detection, and management of reproductive cancers, especially cervical cancer

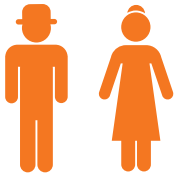
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods

Safe abortion services and treatment of complications of unsafe abortion

Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence

Information, counselling, and services for sexual health and wellbeing

Prevention and treatment of HIV and other sexually transmitted infections



50 and beyond

POST REPRODUCTIVE AGE

Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence

Information, counselling, and services for sexual health and wellbeing

Prevention and treatment of HIV and other sexually transmitted infections

Prevention, detection, and management of reproductive cancers, especially cervical cancer

Menopausal and post menopausal counseling and morbidities

15–49

REPRODUCTIVE AGE AND ADULTHOOD

Prevention, detection, and management of reproductive cancers, especially cervical cancer

Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods

Safe abortion services and treatment of complications of unsafe abortion

Information, counselling, and services for subfertility and infertility

Prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence

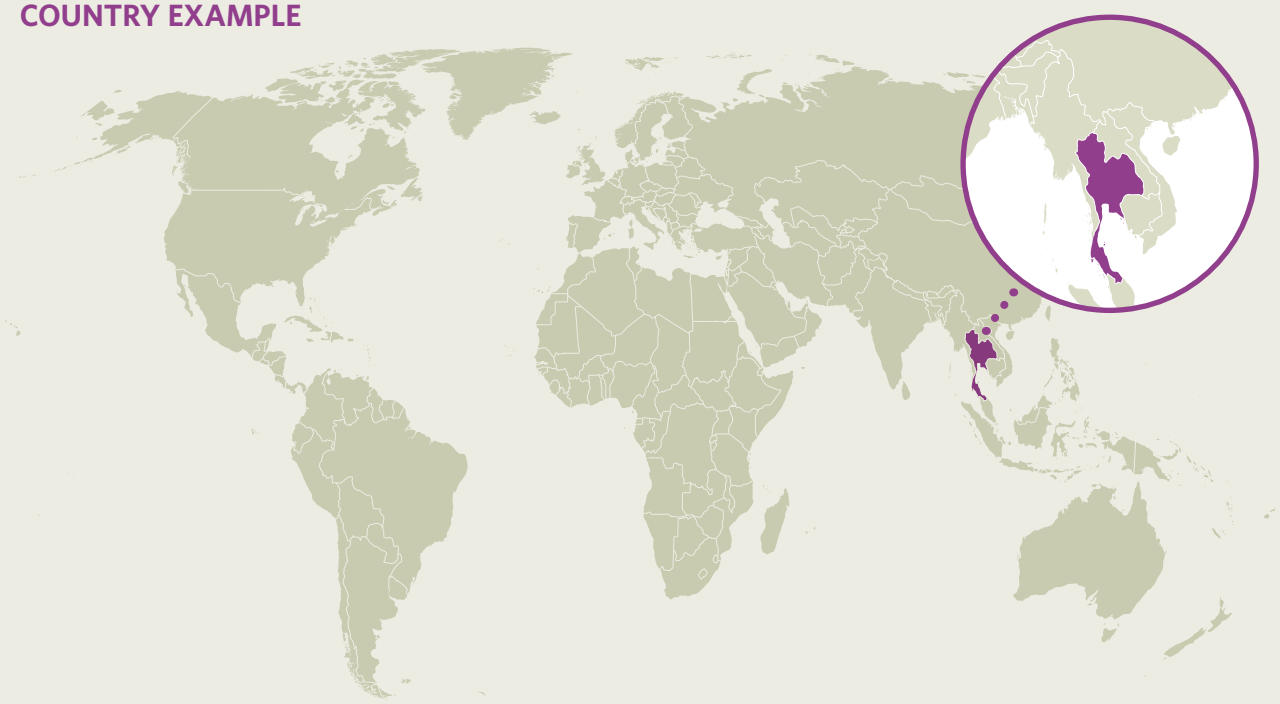
Information, counselling, and services for sexual health and wellbeing

Prevention and treatment of HIV and other sexually transmitted infections

Comprehensive sexuality education

Antenatal, Childbirth, and postnatal care

COUNTRY EXAMPLE



THAILAND

ON THE PATHWAY TOWARDS UNIVERSAL ACCESS TO SRHR

Thailand has achieved a high level of sexual and reproductive health service coverage as a result of targeted policies and programmes that began in the 1970s. This progress was greatly accelerated by the launch of Thailand's universal health scheme in 2002, which simultaneously narrowed the equity gap between both social groups and regions. In addition to UHC, three further health insurance schemes, including one specifically aimed at migrant workers, provide financial risk protection for the entire population. Almost all sexual and reproductive health services are covered under the schemes – universal coverage for SRHR in Thailand is a reality today.

In line with steady increases in access to family planning and the availability of contraceptives, and the concomitant contraceptive prevalence rate (78 per cent in 2015), the total fertility rate fell from 6.2 children per woman in 1960 to 1.5 in 2019. In addition, Thailand reached the MDG targets for maternal health well before the target year 2015, with the maternal mortality ratio amounting to 20 maternal deaths per 100,000 live births. Thailand further achieved successes in that it eliminated mother-to-child transmission of both HIV and syphilis, as certified by WHO in 2016. The country's response to HIV is further noteworthy, with sharp declines in both the incidence of HIV infection and AIDS-related deaths since 2000. In 2014, the eligibility criteria for antiretroviral therapy (ART) changed and ART is now offered to all people living with HIV. As the prevalence of HIV infection among young people (age 15–24 years) has not decreased as anticipated, regulations requiring parental consent for HIV testing of adolescents were revised in 2014 to improve HIV prevention for this key population.

Some areas still require attention, as early marriage remains common, the adolescent birth rate is higher than the regional average and the incidence of unsafe abortion is high. Cultural, societal and financial barriers prevent undocumented migrants and other key populations from accessing sexual and reproductive health services, and the realization of the rights of a large number of people is thus lagging behind. Addressing these issues cannot be achieved by the health sector alone, but requires effective multisectoral cooperation and collaboration with other government sectors.

A CHANGING WORLD:

GLOBAL TRENDS AND IMPLICATIONS FOR SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

The ICPD Programme of Action was groundbreaking in that it linked reproductive rights to human rights. The right to sexual and reproductive health was defined as an integral part of the "right to the highest attainable standard of physical and mental health" enshrined in the International Covenant on Economic, Social and Cultural Rights (United Nations, 1967). This was a paradigm shift. Family planning was no longer merely aimed at reducing fertility and decreasing population growth but was seen as a means to empower women and to promote rights and choices in relation to reproduction. The ICPD recognized that a woman's sexual and reproductive health and well-being encompass not only her access to, and use of, contraception, but also many additional factors: her ability to prevent and manage the complications of unsafe abortion, her capacity to avoid or receive treatment for STIs, including HIV infection, and the care that she receives during pregnancy and childbirth. In addition, the prevention and management of infertility and reproductive tract cancers were also included in the definition of sexual and reproductive health (United Nations Population Fund, 2014).

Sexual and reproductive health and sexual and reproductive rights are centred around individual autonomy and the ability to make choices regarding individuals' own reproduction and sexuality to enjoy the highest attainable standard of health. In addition, sexual rights encompass the rights of people to express their individual sexuality, the rights of adolescents and youths to receive CSE and sexual and reproductive health services and women's and girls' rights to be free of sexual and gender-based violence and coercion. In contrast to reproductive rights,5 and despite the strong support for SRHR among many governments, civil society and the general population, no consensus on sexual rights has been reached by all the Member States of the United Nations in any globally negotiated commitment.

Over the 25 years that have passed since the first ICPD in Cairo, the global context has shifted considerably, with implications for SRHR. For instance, fertility rates have fallen greatly almost everywhere, but still remain high in Africa and in many low-income countries, where most of the population growth in the 21st century will occur. By 2030, more than one-quarter of the world's children will live in Africa. Governments in these countries that are proactive and plan for ways to meet the SRHR needs of a growing population will be better placed to meet rapidly increasing needs. In addition, the group in most need of SRHR services and information, those of reproductive age, will grow in relative size in the poorest countries, but shrink in higher income countries.

There has been a great improvement in the level of education among women in the world and the gap between female and male educational attainment is gradually decreasing. However, there are still large differences between and within countries, and female education levels remain low in some regions. Tackling these disparities is crucial, as higher education attainment among women is associated with their increased ability to have control over their

5 Women's right to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so.

sexual and reproductive health and to access SRHR information and services (Patton and others, 2016). Furthermore, the expected general reduction in poverty levels will also be likely to have positive effects on SRHR. With an increase in income, people are better equipped to access health services and avoid health risks.

Over the last decades, the number of refugees or forcibly displaced people has increased dramatically, reaching 70.8 million by 2018 (United Nations High Commissioner for Refugees, 2019). It is challenging to provide essential sexual and reproductive health services in humanitarian settings or in regions affected by conflict, leading to high numbers of preventable maternal deaths taking place in countries affected by conflict, displacement and natural disasters (International Planned Parenthood Federation, 2018). Moreover, gender norms and patriarchal structures that drive sexual and gender-based violence have implications for the prevalence of STIs, unintended pregnancies and consequently unsafe abortions in contexts with restrictive legislation.

ACHIEVEMENTS AND AN UNFINISHED AGENDA

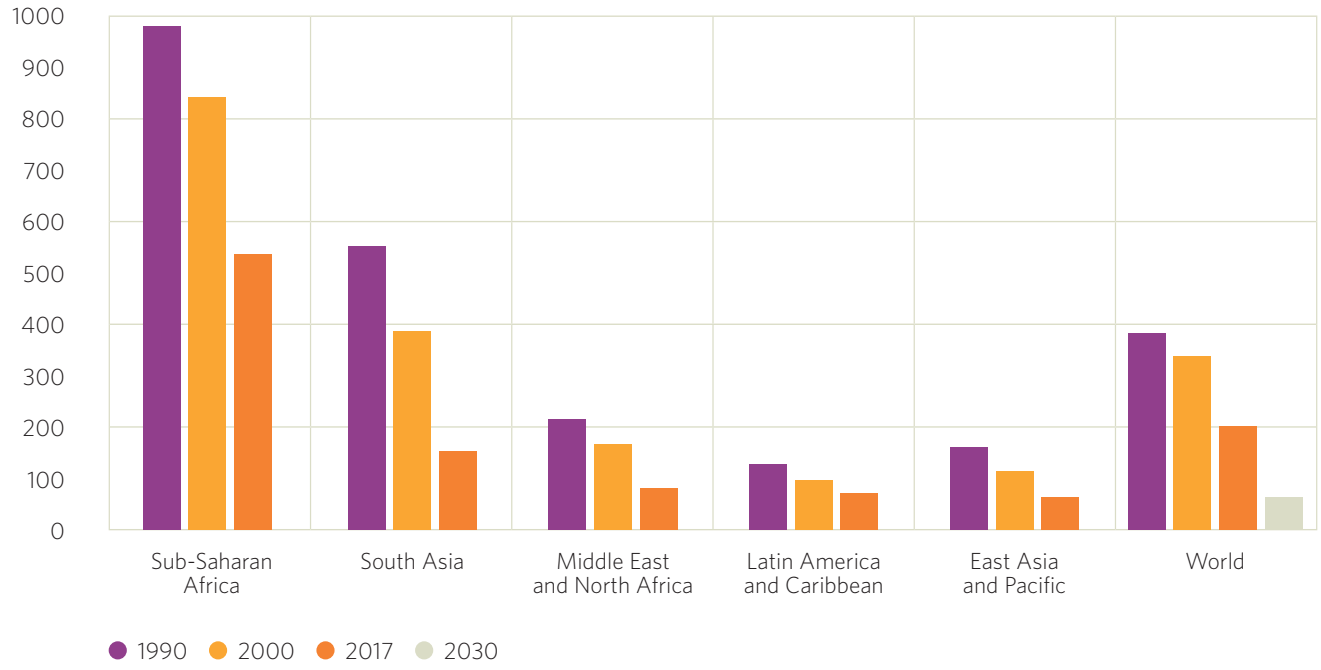
Much has been achieved since the ICPD in 1994. The average number of births per woman was 2.9 in 1994 and has been reduced to 2.4 in 2019; the fertility rate in the least developed countries decreased from 5.6 in 1994 to 3.9 in 2019; and the number of women dying from pregnancy-related causes decreased from 369 per 100,000 live births in 1994 to 211 in 2017, but with large variations between regions (Figure 3). New HIV infections have been reduced by 40 per cent and AIDS-related deaths by 55 per cent since their peaks (Joint United Nations Programme on HIV/AIDS, 2019). More and more SRHR interventions, for example family planning, and testing and treatment for HIV infection and AIDS, are also increasingly integrated in country health systems. In addition, the human papilloma virus (HPV) vaccine has been introduced nationwide in 85 countries around the world.

Despite the substantive gains in reducing sexual and reproductive health-associated morbidities and mortality and in strengthening sexual and reproductive rights since 1994, we are lagging behind. Reproductive rights are still out of reach for too many people, including, for instance, the more than 200 million of the 885 million women in developing regions[6] who wish to prevent a pregnancy but cannot access, or do not wish to use, modern contraceptive information and services. Unmet need for contraceptives is particularly high among adolescents. Of the 38 million sexually active women aged 15–19 years, more than half are not using contraceptives (Figure 4).

6 According to United Nations Population Division classifications, developing regions comprise Africa, Asia, Latin America and the Caribbean, and Oceania, excluding Australia, Japan and New Zealand.

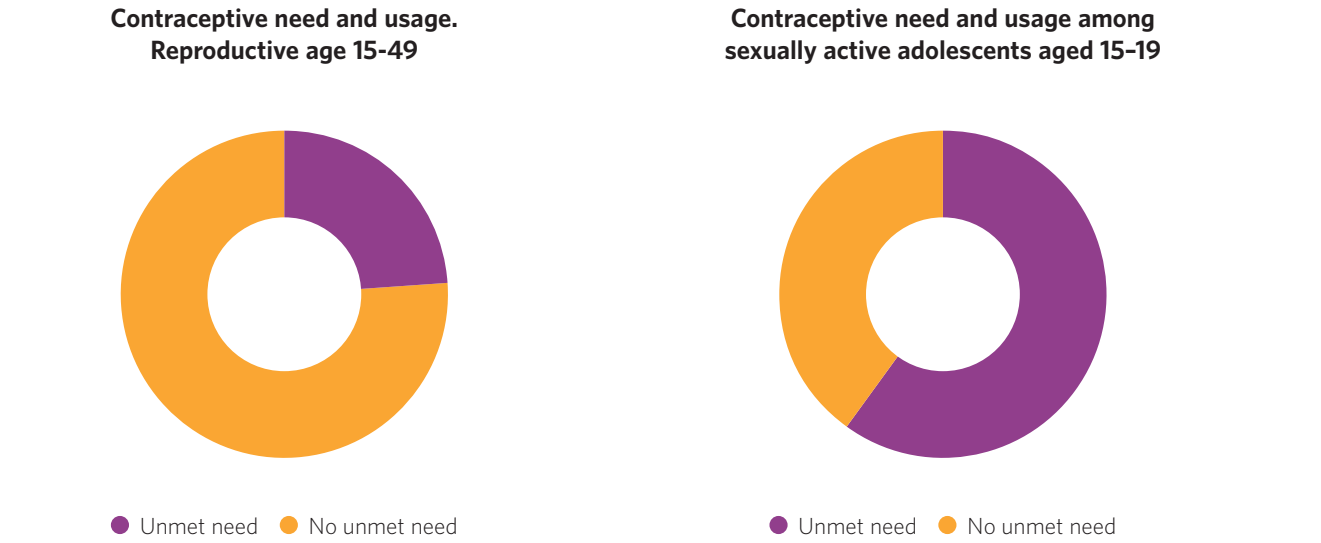
Figure 3. Declines in maternal mortality ratio 1990–2017.

211 women died for every 100,000 live births in 2017. We aim for <70 deaths for every 100,000 live births by 2030.



Source: WHO, UNICEF, United Nations Population Fund and World Bank (2019). Trends in Maternal Mortality: 1990 to 2017. Geneva: WHO.

Figure 4. Contraceptive need and usage among women of reproductive age and sexually active adolescents aged 15–19 years.

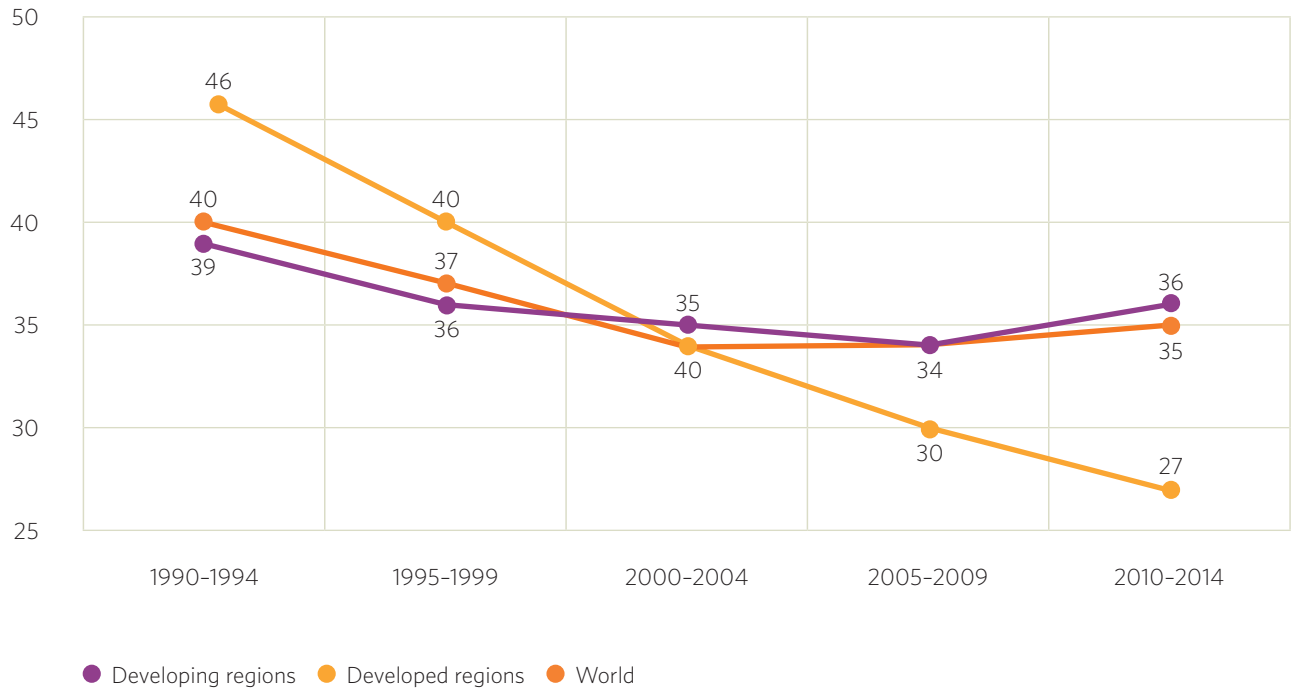


Source: Guttmacher Institute: https://www.guttmacher.org/sites/default/files/factsheet/adding-it-up-contraception-mnh-2017.pdf and https://www.guttmacher.org/sites/default/files/report_pdf/adding-it-up-adolescents-report.pdf

The need for sexual and reproductive health services is high among minority ethnic groups, young people (particularly adolescents), unmarried people, LGBTI+ individuals, people with disabilities, and the rural and urban poor. Among poorer women, not only is the unmet need for contraception more pronounced, but also the maternal mortality rates are markedly higher (Starrs and others, 2018). Low-quality care, inadequate facilities and supplies, discriminatory laws, financial barriers and dismissive treatment or mistreatment by service providers contribute to preventing women and girls from accessing, or wishing to access, services. Every year, more than 25 million abortions that are classified as unsafe[7] take place worldwide. Abortions are more common in developing countries (Figure 5) and a large proportion of these are unsafe. An estimated 6.9 million women in developing regions sought treatment for complications from an induced unsafe abortion in 2012 (Singh and Maddow-Zimet, 2016). About 8–11 per cent of all maternal deaths are related to abortion, translating to some 22,800–31,000 lives lost each year (Singh and others, 2018).

Figure 5. Number of abortions per 1,000 women aged 15-44 years.

The annual abortion rate has declined significantly in developed regions, but not in developing regions.



Source: Guttmacher Institute. Abortion Worldwide 2017. Uneven Progress and Unequal Access, Guttmacher Institute, New York, 2018.

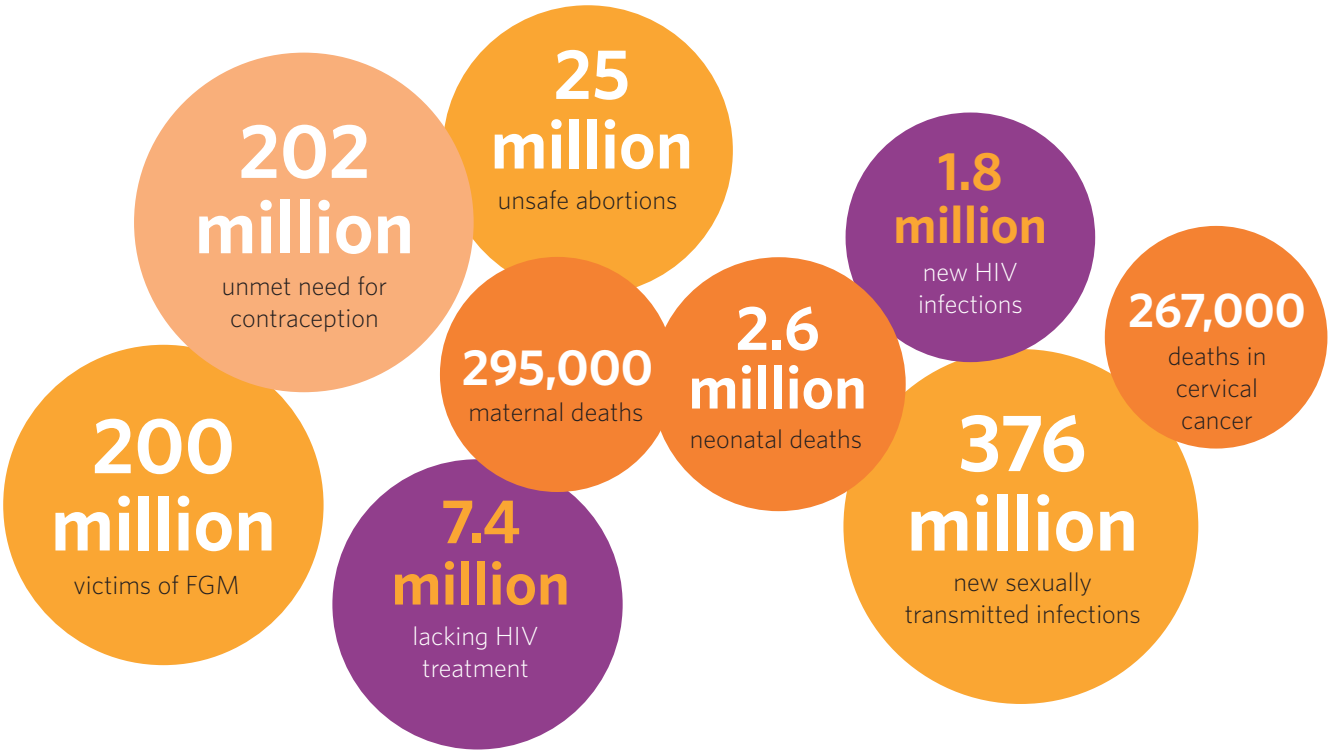
7 Defined by WHO as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking minimal medical standards or both.

Adolescents are a key population for nearly all sexual and reproductive health services. From age 10 to 19 years, adolescents experience major transitions, including the onset of puberty and, for some, the beginning of sexual activity, cohabitation or married life and childbearing (Starrs and others, 2018). Very young adolescents, aged 10–14 years, are particularly vulnerable as they have no or limited access to appropriate sexuality education in many settings and exposure to sexual coercion and/or sexual violence is common (Woog V and Kågesten, 2017). At the same time, social norms, stigma, laws and policies, including age of consent restrictions, often hinder adolescents from accessing contraceptives and other sexual and reproductive health services. Adolescence is a time when future health and SRHR needs are defined. Early marriage or parenthood and little education will have a negative impact on health and will hamper the attainment of SRHR (Patton and others, 2016).

Reaching, and fully realizing the rights of, adolescents and other long-excluded groups can be difficult but is a central priority in realizing the ICPD agenda and achieving universal access to SRHR. Services need to be not only accessible but also of good quality, acceptable, confidential, free of judgement or coercion and targeted to meet identified needs.

Despite the large recognized need and despite the evidence of impact on mortality and ill-health over time, there are many issues that are often overlooked or underfunded. These include safe abortion services, CSE and sexual and reproductive health services for adolescents, the prevention and treatment of gender-based violence, female genital mutilation (FGM) and engaging men as partners in SRHR (Starrs and others, 2018).

AN UNFINISHED AGENDA



WHAT DOES THE EVIDENCE TELL US?

A CLOSER LOOK AT THE ESSENTIAL SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INTERVENTIONS

There is ample evidence to support the provision of the SRHR interventions included in the Guttmacher–*Lancet* Commission's definition and package. These interventions have been shown to be effective in reducing the sexual and reproductive disease burden and hence in improving individuals' sexual and reproductive health and well-being. In addition, investments in SRHR have been shown to provide good value for money and to yield enormous social and economic returns for families and societies that pay dividends across generations as people's care, health and well-being improve. A United Nations Educational, Scientific and Cultural Organization (UNESCO) cost-effectiveness analysis of CSE programmes in several countries suggested that the programmes were cost-effective and even cost-saving (UNESCO, 2018). Similarly, the global Disease Control Priorities Project found family planning to be among the most cost-effective of all health interventions (Horton and Levin, 2016). Investments in family planning and access to modern contraceptives were also estimated to yield enormous returns (Singh and others, 2014; United Nations Population Division, 2009; Vlassoff and others, 2009). In addition, cost-effectiveness studies in Afghanistan, India, Mexico and Nigeria have evaluated different integrated packages of maternal and newborn care and reported numbers well below WHO-recommended cost-effectiveness benchmarks (Carvalho and others, 2013; Erim and others, 2012; Goldie and others, 2010; Hu and others, 2007). The provision of unsafe abortion is cost-saving compared to the costs incurred by unsafe abortions and results in reductions in complications and mortality (Hu and others, 2009, 2010). Medical abortion has been suggested to enhance access to safe abortion while freeing up resources and decreasing total costs (Prinja and others, 2015). Several studies conducted across a wide range of low- and middle-income countries (LMICs) have found HPV vaccination in adolescent girls to be cost-effective in the prevention of cervical cancer (Campos and others, 2012; Goldie and others, 2008a,b; Jit and others, 2014). Visual inspection of the cervix with acetic acid was further shown to be very cost-effective in LMICs within the scope of a screening and treatment approach (Campos and others, 2015a; Denny and others, 2016; Ginsberg and others, 2012; Goldie and others, 2001, 2005; Praditsitthikorn and others, 2012) and provider-collected HPV testing[8] has been found to be very cost-effective compared with "do nothing" or conventional cytology-based screening programmes (Campos and others, 2015a,b, Denny and others, 2016; Ginsberg and others, 2012; Goldie and others, 2001, 2005; Levin and others, 2010).

These studies reflect only a small part of the evidence available to support the argument that the proposed package of essential interventions should be included in countries' UHC reforms and made universally available to the population. A more comprehensive review of the evidence for the proposed interventions can be found as a supplement to this report.

8 A method where the care provider collects HPV DNA through swabbing the cervix.

THE WAY FORWARD:

INCREASED INVESTMENTS AND PROGRESSIVE REALIZATION

Ultimately a political choice, aiming for UHC and universal access to SRHR are the responsibilities of every country and national government. In order to move towards universal access to SRHR, countries are encouraged to adopt the comprehensive definition of SRHR proposed by the Guttmacher–*Lancet* Commission, to progressively expand equitable access to the recommended package of SRHR interventions and to apply a life course perspective throughout this approach.

Political support is critical to establishing commitment for a comprehensive approach to SRHR in UHC. It is equally important, however, to translate political commitments into actionable steps for implementation. Countries need to define the specific steps of their unique pathway towards UHC, including universal access to SRHR. Based on examples and countries' progress to date, a set of broader steps and good practices have been identified in an attempt to guide the contextualized process to achieve these goals. These are:

- analyse the SRHR needs of the population and interlinkages between essential SRHR interventions;
- map and mobilize all key stakeholders relevant for implementing the package of interventions;
- analyse supply- and demand-side requirements in implementing the essential SRHR package;
- prioritize interventions and develop a UHC benefits package based on the SRHR needs of the population;
- mobilize and coordinate funds to enable and effectively fund interventions;
- progressively realize the package of essential SRHR interventions as part of UHC.

COUNTRY EXAMPLE

URUGUAY

COMPREHENSIVE INCLUSION OF SRHR IN THE CONTEXT OF UHC

In 2007, Uruguay spearheaded the health sector reform, including the creation of its Integrated National Health System, with a clear objective of achieving UHC. Currently, 60 per cent of the population have health insurance coverage from private institutions and 40 per cent have health insurance coverage through the public sector. The health sector reform, driven by intersectoral health policies, aimed to improve the population's quality of life. This includes universal access and coverage, strong focus on equity and inequalities, continuity of care, health promotion and prevention, and comprehensive care generating important progress in SRHR.

For the past 15 years, Uruguay has taken important steps in the development and implementation of a SRHR public policy, as part of health system reform addressing universal access and coverage. The SRHR package of interventions is composed of modern contraception (quality contraception provision, ensuring the availability of a wide range of contraceptive methods, including long-acting reversible contraceptives, free of charge or at low cost), safe abortion, antenatal, perinatal and postnatal including newborn care, screening and management of reproductive health cancers, CSE and information and counselling. It is important to note that there is a strong focus on comprehensive adolescent health interventions, including SRHR, mental health and nutrition, among others. To accelerate progress in the reduction of adolescent unintended pregnancies, a national intersectoral strategy was launched in 2018 and is under full implementation.

Unmet need for family planning is 8.9 per cent, and 91.7 per cent of women and 85.9 per cent of men regularly use modern contraceptive methods. Important progress has been made in reducing the adolescent fertility rate, which was stagnant but now has decreased from 57 per 1000 live births in 2015 to 36 per 1000 live births in 2018. Research indicates that improved universal access to and coverage of the SRHR package has contributed to this reduction. The adolescent fertility rate is now one of the lowest in the region.

Legal reforms have been critical in supporting the exercise of sexual and reproductive health rights. These include Law 18426 on the Right to Sexual and Reproductive Health, adopted in 2008, and Law 18987 on the Voluntary Interruption of Pregnancy, adopted in 2012. These laws state that it is the responsibility of the State to guarantee SRHR for all, establishing mandatory universal coverage of all sexual and reproductive health policies and programmes at the primary health-care level. It should guarantee quality, confidentiality and privacy of services; should have appropriately trained human resources, with both technical and communication skills; and must incorporate the gender perspective in all actions and conditions for users to make free and informed decisions. In addition, it should promote inter-institutional coordination, emphasizing the role of formal education in supporting SRHR. Civil society participation is strong, with a great focus on monitoring the implementation of laws and policies.

ANALYSE THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS NEEDS OF THE POPULATION AND INTERLINKAGES BETWEEN ESSENTIAL SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INTERVENTIONS

Countries' effective and evidence-based decisions to prioritize SRHR interventions hinge on a solid understanding of the existing SRHR needs within their population. This requires granular and disaggregated data on the burden of disease to distinguish between the needs of different groups and to take adequate account of the needs of particularly vulnerable groups. The WHO list of core health indicators (WHO, 2018) provides a good resource for identifying useful indicators for analysis, and country-level health management information systems often contain useful granular data that could be further analysed and complemented with population and health facility survey data.

Furthermore, countries need to be cognizant of the interlinkages between the different package components and different life stages. Such knowledge is critical to be able to make informed decisions on how interventions should be prioritized and implemented, as one intervention can have implications for other interventions. The interlinkages can be illustrated through several different examples. Not providing the cost-effective HPV vaccination to young girls aged 9–13 years has ramifications in terms of cervical cancer morbidity and mortality in women of reproductive age, and additionally poses an economic burden on countries' health systems through the high costs of cancer care. Another compelling example is the prevention of mother-to-child transmission of HIV. In addition to adequate access to effective ART, prevention could start much earlier in the life course, for instance by providing both CSE and access to a choice of modern contraceptive methods to equip people with the skills and knowledge to protect themselves from HIV infection. Age-appropriate and evidence-based CSE has been shown to lead to better sexual and reproductive health. Correspondingly, neglecting CSE in adolescence is associated with a higher risk of acquiring an STI, including HIV infection, and an increased prevalence of unwanted pregnancies. This not only increases the burden of disease on individuals, but also incurs higher costs for the health system at later stages of life.

MAP AND MOBILIZE ALL KEY STAKEHOLDERS RELEVANT FOR IMPLEMENTING THE PACKAGE OF INTERVENTIONS

Determinants of sexual and reproductive health include political, environmental, commercial, financial social and cultural factors. Although much of the responsibility for delivering sexual and reproductive health services lies within Ministries of Health, other SRHR interventions lie beyond the realms of the mandate of Ministries of Health and are the task of other parts of government, for instance CSE, parts of the services for survivors of sexual and gender-based violence and education and infrastructure for reducing preventable maternal and newborn mortality and morbidity. To realize a comprehensive approach to universal access to SRHR and UHC, action requires engagement by different sectors, such as the education, gender, infrastructure, finance and energy sectors, as well as both public and private stakeholders. UHC also implies a focus beyond curative, palliative and rehabilitative services to also cover health promotion and prevention. Such multisectoral, multi-stakeholder and comprehensive action has often proved challenging in practice, with health plans, policies and programming mostly focused on health-care services. In many countries, health services are organized around packages of health interventions that are operationalized through clinical guidelines, which often leads to a focus on clinical services and less consideration of preventive services or risk reduction activities.

A first step to enable multisectoral collaboration is to carefully map and analyse which stakeholders are currently doing what. Examples of questions to be asked include "Who is providing the interventions outlined in the essential SRHR package?", "Are there interventions that are currently not provided?", "How is funding channelled for providing these interventions?" and "What forums for multisectoral collaboration currently exist and what can be learned from them?".

REGIONAL EXAMPLE

EASTERN EUROPE AND CENTRAL ASIA

DEVELOPING POLICIES FOR A COMPREHENSIVE APPROACH TO SRHR

Despite significant progress being made in countries in Eastern Europe and Central Asia since the ICPD in 1994, universal access to SRHR remains a challenge. In most countries, maternal and child health has been prioritized as the main, and often only, sexual and reproductive health programme in UHC reforms. Vertical programmes, for example for HIV and AIDS, served the purpose of an immediate response, but have been less efficient in addressing other SRHR areas. As a result, access to integrated sexual and reproductive health services at the primary health-care level is limited and out-of-pocket spending on SRHR remains high.

The Action Plan for Sexual and Reproductive Health 2017–2021 (World Health Organization Regional Office for Europe, 2016) provides a strategic framework for SRHR aimed at accelerating the development of national plans for SRHR in European and Central Asian countries. The SRHR action plan was approved by 50 European Member States in 2016 and is based on the ICPD commitments and on Agenda 2030 aspirations. It covers essential sexual and reproductive health services and emphasizes a rights perspective. The action plan also calls on governments to "strengthen health services for effective delivery of high-impact, evidence-based interventions and UHC". The Member States are reporting on progress at the national level in 2019 and 2021.

To date, 6 out of 17 countries in the UNFPA Eastern Europe and Central Asia region (Albania, Georgia, Moldova, North Macedonia, Serbia, Tajikistan) have developed national SRHR action plans.

North Macedonia has developed the National SRH Action Plan (2018–2020). The process for developing the action plan was comprehensive and inclusive of key stakeholders, including vulnerable groups. The action plan was also aligned with regional and global commitments and strategies. The government approved the plan in 2018, demonstrating its commitment to move the SRHR agenda forward. The action plan accelerates the integration of SRHR into UHC, with eight focus areas: family planning, maternal and newborn health, HIV infection and STIs, prevention and early detection of breast and cervical cancer and gender-based violence. Special efforts were made to protect vulnerable groups (recipients of social welfare, those with disabilities, etc.) and to ensure universal access to sexual and reproductive health services.

In **Serbia**, the regional action plan guided the development of the National Programme on Protection and Promotion of Sexual and Reproductive Health 2017. This comprehensive SRHR programme is structured around activities related to the fulfilment of human rights, family planning, maternal health, STIs, counselling services for adolescents and the prevention of gender-based violence. The Serbian Ministry of Health and the UNFPA country office also developed a costed action plan to enable the efficient allocation of resources and to ensure the monitoring of activities and indicators for follow-up.

In **Moldova**, the National Programme on Sexual and Reproductive Health and Rights 2018–2022 was adopted in 2018, making Moldova one of the first countries in the European region to adopt such a national policy document for SRHR. The policy is aligned with the 2030 Agenda for Sustainable Development, the ICPD Programme of Action and the European Action Plan for Sexual and Reproductive Health. The Moldovan programme aims to ensure universal access to SRHR services, including in humanitarian crises. More specifically, it is focused on vulnerable groups, including adolescents and women with disabilities. Furthermore, the programme aims to improve the quality of care by applying a human rights-based and patient-centred approach to service provision. The programme also prioritizes population information and education on SRHR and cross-sectoral coordination in addressing the SRHR needs of the population. Government commitment is illustrated through the programme's costed action plan, which has a dedicated government budget line for centralized procurement of contraceptives for vulnerable groups, including adolescents.

ANALYSE SUPPLY- AND DEMAND-SIDE REQUIREMENTS IN IMPLEMENTING THE ESSENTIAL SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS PACKAGE

A thorough analysis of the context-specific supply-side and demand-side requirements is critical in order to tackle barriers to universal access to SRHR. Supply-side challenges include the lack of infrastructure to deliver an essential package of SRHR interventions. Services might be prioritized by the government without taking into account supply-side constraints or the requirements necessary to upgrade service delivery systems and make them fit for purpose. This could include ensuring a supply chain of drugs and commodities for health centres, or pre-service education and continuous training and support of health workers to ensure that health centres are adequately staffed and that provided services meet quality of care standards. In many settings, governments promise to provide services that, in reality, are not consistently available in the public sector, which requires patients to purchase services out of pocket in the private sector. In order to advance universal delivery of SRHR interventions, prioritizing and including services in health benefits plans must be complemented with appropriate routine data collection and health service availability, readiness and quality assessments to ensure that the health system is equipped and able to deliver the interventions. Furthermore,

costed investment plans for systems strengthening should be developed. Experiences to date show that many countries are struggling with similar supply-side challenges. Cross-country exchange with regard to how supply-side challenges have been overcome can therefore be useful to identify strategies to effectively address such challenges.

On the demand side, lack of information and knowledge of SRHR needs, as well as the stigmatization and criminalization of some SRHR services and entitlements, and sexual behaviours have implications for people's health-seeking behaviour. Given the scope of economic, political, social, cultural and geographic factors that infringe on individuals' health care-seeking behaviour, an expansive set of multisectoral strategies is required, in addition to health system strengthening, in order to catalyse action. It is important to promote policies, laws and initiatives that support non-stigmatizing, culture- and gender-responsive SRHR programmes and services. Similarly, it is crucial to foster health promotion, as well as strengthen leadership at the community level, social support and individual – especially women's and girls' – empowerment, in order to increase demand for SRHR services and social accountability mechanisms to achieve sustainable improvements in SRHR.

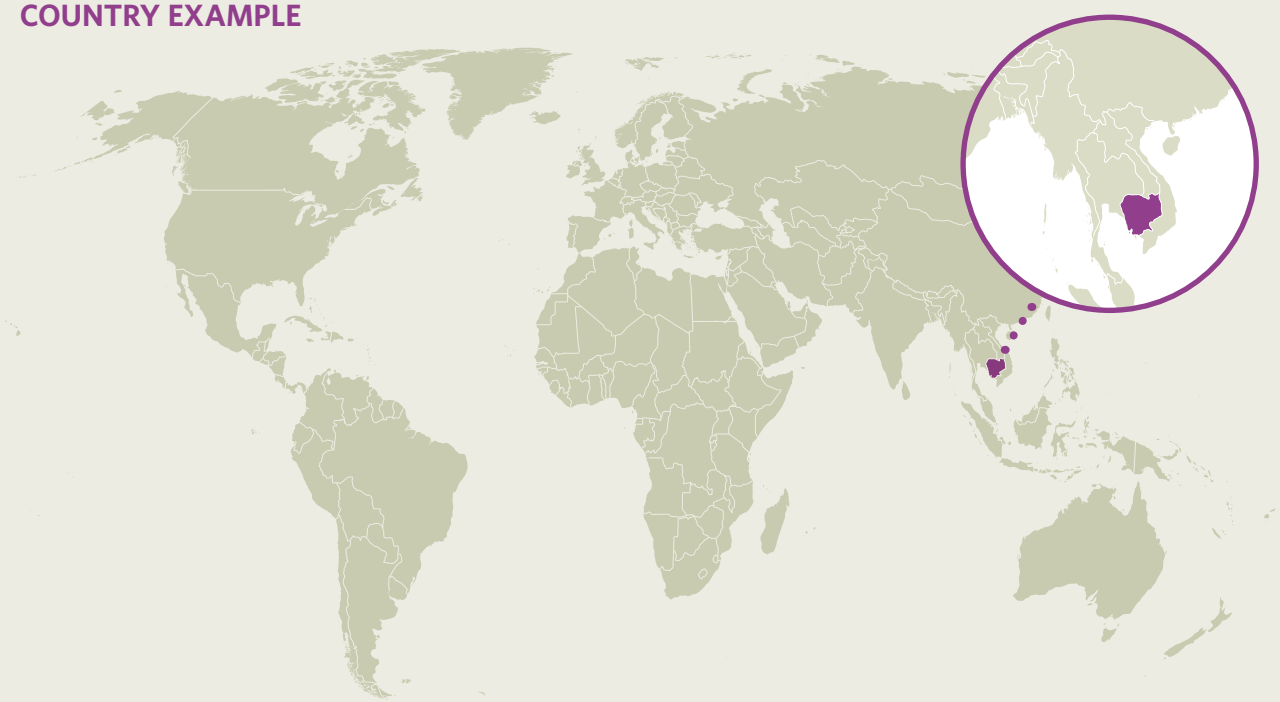
PRIORITIZE INTERVENTIONS AND DEVELOP A UNIVERSAL HEALTH COVERAGE BENEFITS PACKAGE BASED ON THE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS NEEDS OF THE POPULATION

The previous steps of analysing country-specific SRHR needs, available resources and challenges are the basis for prioritizing which interventions to provide initially and at which level of the health system, and how to incrementally increase SRHR service availability to achieve maximum health benefits. Access to SRHR can be universal only if it applies equally to all people. Equity in access is therefore central to the process of prioritizing interventions. The Agenda 2030 principle of leaving no one behind guides countries to put people first, in particular those who currently are underserved, marginalized or discriminated against, including adolescents, people with disabilities and LGBTI+ individuals. SRHR interventions should target the needs of all individuals, which requires countries to work more deeply on applying a rights-based approach. The prioritization process is also a tool to ensure that the focus is placed on delivering the most cost-effective SRHR interventions in a given context, in light of the available resources.

Prioritization processes should be followed by the development of a UHC benefits package that is inclusive of the prioritized SRHR interventions. A benefits package defines a package of interventions that can be feasibly financed and provided according to each country's actual circumstances. By making this benefit package explicit and the development process transparent, citizens can be made aware of which services should be available in the public sector. The health system's capacity to deliver the benefits package further needs to be assessed.

Scaling up any intervention might require investments in one or all of the health system building blocks, for example the workforce, supply chains and infrastructure (WHO, 2007). The resources required from the health system and beyond for ensuring equitable access to the defined SRHR package with quality of care should be defined and costed. Furthermore, national governments can task appropriate agencies/institutions with developing an SRHR strategy that outlines the sectors, functions and other (implementing) partners that need to be involved and defines the roles and responsibilities of each stakeholder, with clear accountabilities and follow-up modalities.

COUNTRY EXAMPLE



CAMBODIA

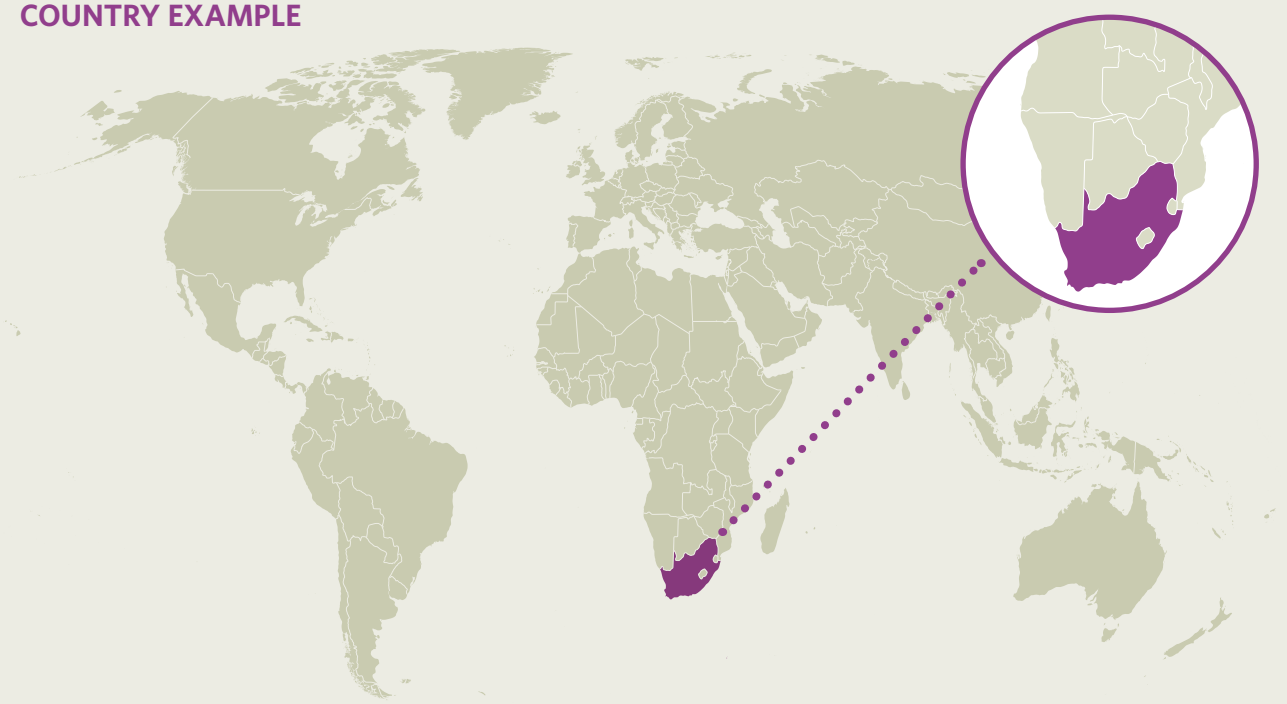
INTEGRATING SRHR SERVICES IN HEALTH CENTRE- AND HOSPITAL-LEVEL BENEFITS PACKAGES

Cambodia has made impressive progress in expanding the services offered for sexual and reproductive health after the almost complete breakdown of the health system under the Khmer Rouge regime in the 1970s and during the civil war of the 1980s and 1990s. Cambodia has adopted policies and programmes in key areas to improve the delivery of sexual and reproductive health services.

Health services in Cambodia are provided in the public and private sector, including by a variety of non-governmental organization-operated not-for-profit health facilities. An important step in the aspiration to achieve UHC in Cambodia has been to define packages of services for public sector facilities. The Minimum Package of Activities stipulates services to be provided primarily at the health centre level and the Complementary Package of Activities lists services to be provided in hospitals. These packages are delivered with fixed fees for patients, and the Health Equity Fund has been launched across the country to enable the poor to access free health-care services. The service packages include medical services for sexual and reproductive health: maternal health care (including emergency obstetric and newborn care), family planning, abortion, treatment of HIV and AIDS and STIs and cervical cancer prevention, detection and treatment.

Fixed and transparent user fees for sexual and reproductive health services provide some level of protection against financial hardship, especially as the fee levels are set in consultation with communities and services are free for the poor. However, financial barriers to universal access to SRHR still exist. Financial risk protection mechanisms for the poor do not extend to the private sector, which is an important provider of sexual and reproductive health services, e.g. family planning and abortion services.

COUNTRY EXAMPLE



SOUTH AFRICA

DEVELOPING A HEALTH BENEFITS PACKAGE FOR ROLLING OUT NATIONAL HEALTH INSURANCE

South Africa is moving towards UHC through health system reform, including the introduction of National Health Insurance (NHI). The current health-care system is highly inequitable, with 51 per cent of health spending providing services to 16 per cent of the population. The NHI aims to address these inequities by providing a package of primary health-care services to vulnerable populations by 2021 and to the whole population by 2025.

South Africa aims to create a single national benefits package, beginning with primary health care and incrementally expanding the provision to all levels of care. It is further intended to ensure that the private sector is also delivering these services at an appropriate level of the health system. At this early stage of the NHI transition, the focus has been on ensuring consistency in definition and thereby quality of services. The package is based on the national Standard Treatment Guidelines for primary health care, which include 813 conditions, relating to different populations and age groups. The adoption of a primary health-care package has helped to ensure the inclusion of many essential SRHR interventions, although services delivered at both secondary or tertiary level and outside the health sector have been omitted. In total, 281 conditions relating to SRHR are captured in the South Africa Health Benefits and, to date, there have been only minor political challenges to the inclusion of even the most controversial elements of SRHR. The process of developing the benefits package has been inclusive of key stakeholders, including civil society, regulatory agencies and the private sector.

Making the process for prioritization inclusive of all key stakeholders, and making decisions around a benefits package transparent, are both part of good governance of the health system. It is an important requirement for constituencies and stakeholders to be able to hold policy-makers accountable and to allow for proper discussions to take place about the goals of the health system, how priorities should be set, including based on ethical principles, and how performance should be assessed. Trade-offs are inevitable, especially when resources are highly constrained, but establishing a transparent process for prioritization and resource allocation will put these trade-offs up for public scrutiny and debate. It is important to actively involve civil society, professional associations, such as medical, midwifery and nursing associations, and communities. It is also important to establish strong links between global, country-level and regional accountability mechanisms in order to bring together diverse stakeholders and streamline the monitoring, reviewing and acting elements of accountability at all levels.

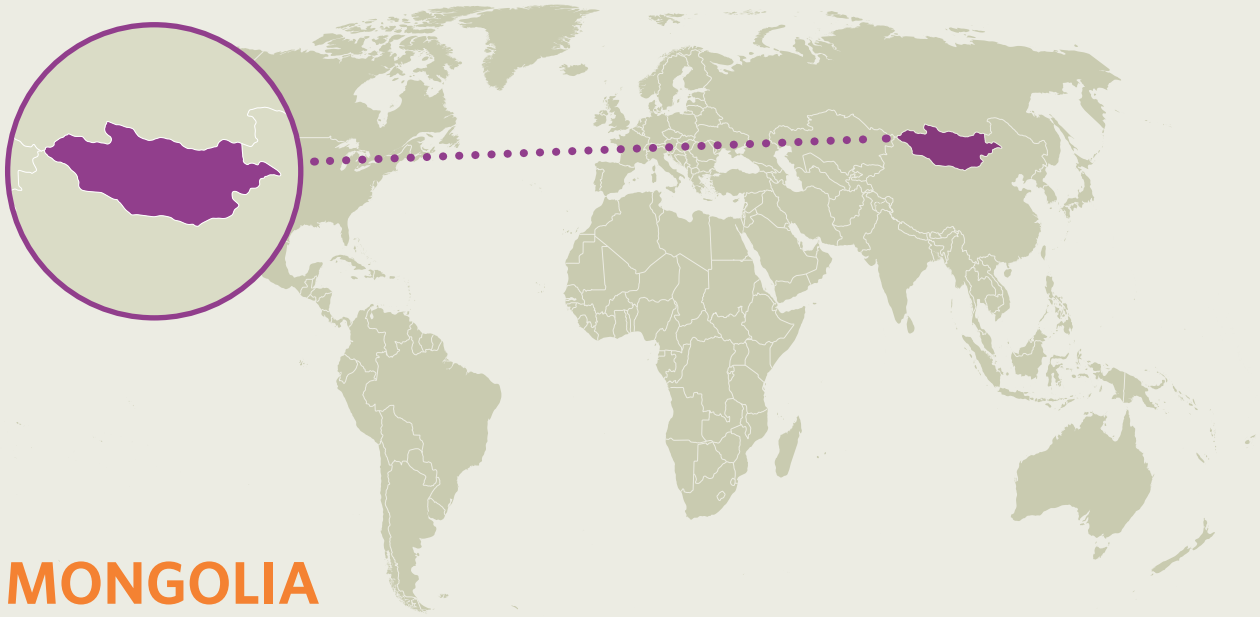
MOBILIZING AND COORDINATING FUNDS TO ENABLE AND EFFECTIVELY FUND INTERVENTIONS

Mobilizing increased domestic resources is critical to be able to sustainably finance a comprehensive approach to SRHR. There are different means to increase domestic resource mobilization by pooling funds, including progressive income taxes, earmarked taxes and health insurance pre-payments. There is no one single answer to the question of which model is best for pooling domestic resources as it depends on the context, but it is crucial to reduce reliance on out-of-pocket spending in health care,

Out-of-pocket payments are direct payments by individuals to service providers at the time of use. Such payments contribute to barriers to accessing services and increase the risk of financial hardship. In many countries, out-of-pocket payments are high and account for a significant proportion of total spending on health. It is therefore critical to increase domestic resource mobilization for SRHR in order to reduce reliance on out-of-pocket spending on health care. This increases financial protection, which is one of key targets of UHC reform.

In low-income countries, development assistance for health represents 25 per cent of total health spending (Global Burden of Disease Health Financing Collaborator Network, 2019). Consequently, increased domestic resource mobilization is particularly necessary in low-income countries to sustainably finance essential SRHR interventions. In these settings, coordination of resources and stakeholders is critical but complicated. External assistance is often earmarked for specific purposes (e.g. family planning or prevention and treatment of HIV and AIDS), which contributes to an often highly fragmented funding landscape for SRHR and can lead to scenarios in which essential interventions that should be prioritized are not provided.

COUNTRY EXAMPLE



MONGOLIA

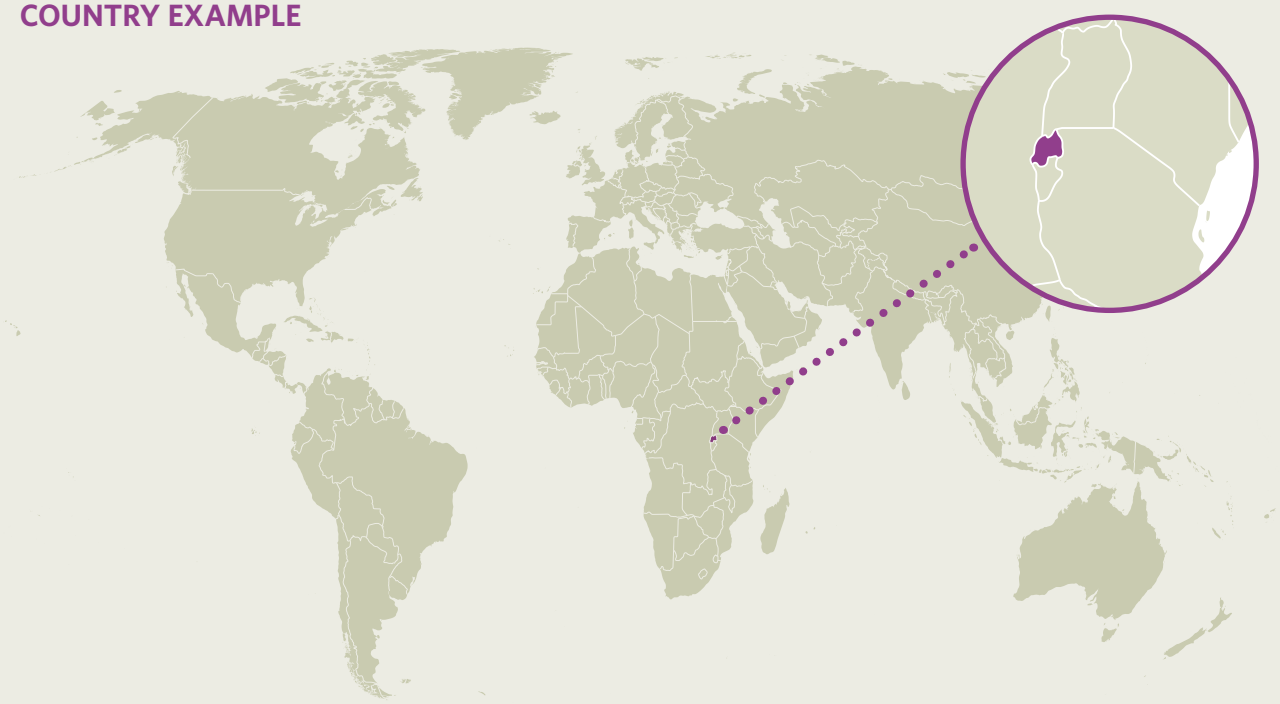
IMPROVING MATERNAL HEALTH AS PART OF UHC

Mongolia has made great progress in reducing maternal mortality and in increasing both antenatal care coverage and skilled attendance at delivery, which are high at about 90 and 98 per cent, respectively. In 2015, the country became one of only nine nations in the world to achieve the MDG maternal mortality reduction target, by reducing the maternal mortality rate to 26 per 100,000 live births. Overall, Mongolia has achieved a 75 per cent reduction in maternal mortality since the late 1990s. Following a startling increase in maternal mortality to 48.8 maternal deaths per 100,000 live births in 2016, the country again managed to halve the rate, to 26.6 per 100,000 live births, in 2017. These recent developments reflect Mongolia's strong political commitment but also the fragility of its health system and its vulnerability to external shocks, including economic difficulties, as faced by the country today.

With regard to the SRHR financial risk protection landscape, Mongolia has a long-term strategy for the development of social health insurance (SHI) (2013–2022), which was adopted in 2013. This includes mandatory SHI, with consistent coverage of about 90 per cent of the population, hence providing a stable financing source for the health sector. The government fully subsidizes the insurance premiums for about 60 per cent of members, including the premiums for children aged less than 16 years, pensioners, mothers of children aged up to 2 years and people living in poverty. The government budget further covers primary-level health-care services, which provide antenatal care and, in rural areas, oversee normal deliveries. At the secondary and tertiary levels of care, which account for 80 per cent of deliveries, co-payments of 10 and 15 per cent, respectively, are required.

However, problems related to quality of care remain and require attention. A 2016 rapid review of maternal deaths concluded that 45 per cent could have been prevented if high-quality and effective antenatal, peri-partum and postnatal care had been provided. In addition, out-of-pocket payments in health financing are still high and negatively affect equity, access and use of health services, even for people with SHI. Aware of its challenges, Mongolia has signalled its commitment to further reduce maternal mortality and to recalibrate its approach to other SRHR areas, for instance family planning, by increasing its budgetary allocation to contraceptives by 12 times, as well as by putting into place detailed national strategies, such as the Sustainable Development Vision 2030. The goals are further underpinned by the "leaving no one behind" principle and are formulated in keeping with the concept of progressive universalism, thus showing Mongolia's commitment to UHC with its principles of equity in access and financial risk protection.

COUNTRY EXAMPLE



RWANDA

COORDINATING EXTERNAL RESOURCES FOR A COMPREHENSIVE HEALTH BENEFITS PACKAGE, INCLUDING SRHR INTERVENTIONS

Rwanda has made significant progress towards UHC, increasing health spending and access to care. Maternal mortality has dropped by 80 per cent, from 1,070 deaths per 100,000 live births in 2000 to 210 deaths per 100,000 live births in 2014/15. In total, 43.9 per cent of pregnant women attend four or more antenatal care visits and 91 per cent of deliveries are now overseen by a skilled attendant.[9] Rwanda's progress is attributed, in part, to significant national leadership, community-focused primary care and implementation of Mutuelles de Santé, a national, publicly financed insurance scheme for the informal sector, which is now managed by the Rwanda Social Security Board and covers over 80 per cent of the population. The Service Package for Health Facilities specifies what services should be provided at each health facility level and the inputs required to implement them. Services are broad but are complemented by national treatment guidelines, clinical protocols and an essential medicines list. The service package, and in turn the Mutuelles de Santé package, includes in a compiled way most of the essential interventions listed in the Guttmacher–*Lancet* Commission

Development partner funding is allocated in line with the priorities of government. For example, external funding provides part of the premium subsidy for the indigent to be beneficiaries of Mutuelles de Santé. This alignment of development partner funding with the service package is possible because the Rwandan government took a leadership role in asking that development partners coordinate funding and allocate it towards national plans. Rwanda conducts an annual resource mapping and partner mapping exercise against health sector needs and asks development partners to coordinate against these plans. In addition, the Mutuelles de Santé scheme has been highly successful in providing coverage to most of the population.

9 Rwanda Demographic and Health Survey 2014/15.

Similarly, coordination challenges also exist for domestic funding, as decisions about health budgets are made across different government agencies (e.g. Ministry of Finance, Ministry of Health, Ministry of Local Government, Civil Service Agency, Insurance Agency, Procurement Agency) and levels of government (federal, regional, district). This can render the coordinated allocation of resources in line with a developed health benefits package difficult.

Several of the interventions included in the essential SRHR package are low cost and cost-effective and, as such, they are within reach for countries with a limited total health expenditure and limited domestic government spending on health. However, as yet, no estimation of the total costs of a comprehensive approach to SRHR has been conducted.

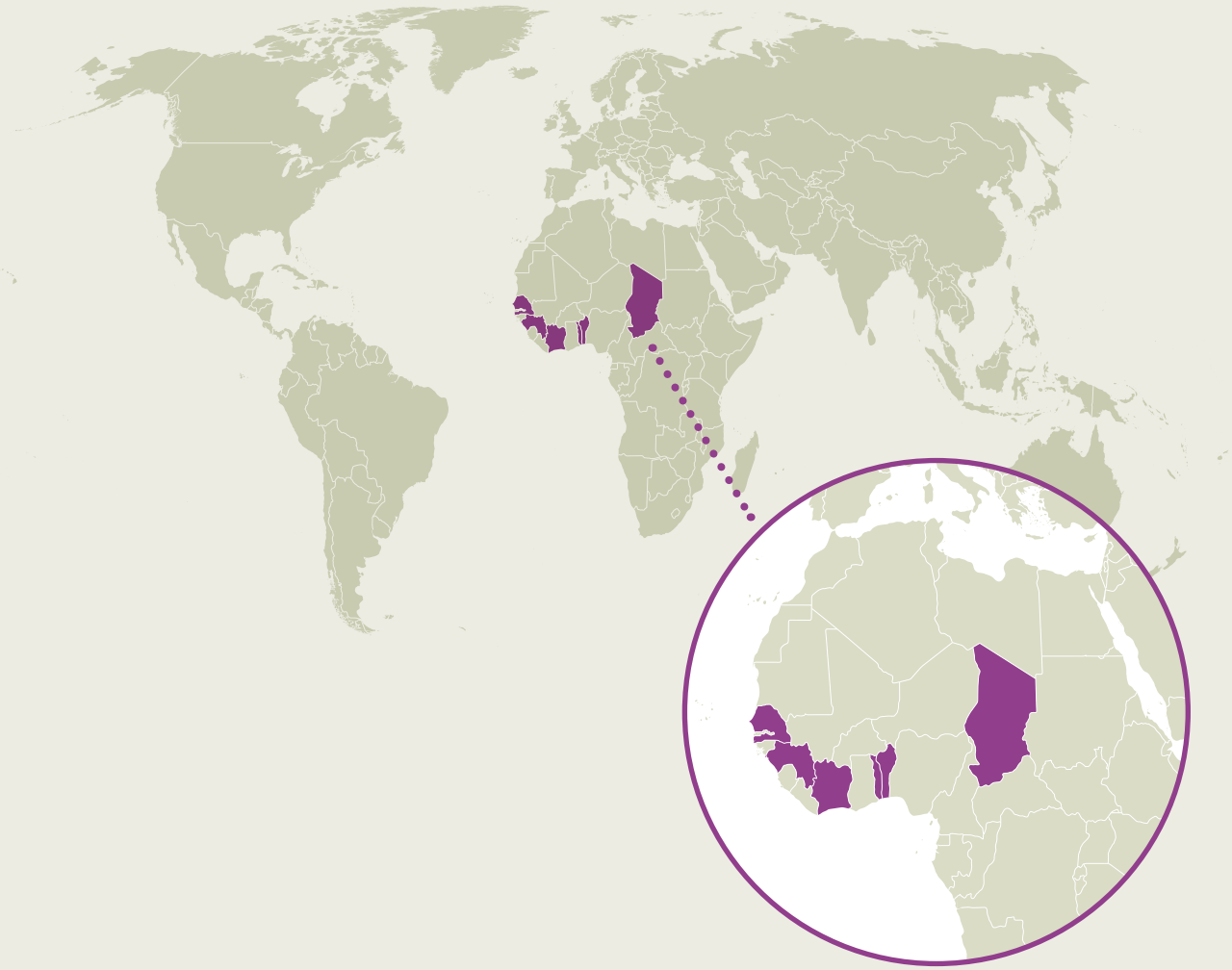
Costs and cost-effectiveness can vary significantly between countries; therefore, country-specific cost estimates for delivering the package of essential SRHR interventions are useful for decision-makers to be able to make evidence-based decisions about how to prioritize resources. Costing should include estimation of the direct costs of interventions and also the cost implications of increasing the coverage of interventions. Adding new interventions, or increasing the coverage of existing interventions, will require investment in systems, for example training of the health workforce, upgrading infrastructure and developing supply chains for commodities. Such investments will come with additional, indirect costs, which are important to estimate to understand the total cost of delivering the essential package of SRHR interventions.

WHO is currently engaging in work to create an online repository of UHC interventions, which can provide useful guidance for countries aspiring to deliver an essential package of SRHR interventions. This forthcoming work will include guidance for all health areas, including SRHR interventions. The database will provide details on WHO-recommended interventions and their resource implications. The repository is intended as a global resource to facilitate discussions at country level around what services to provide within individual health benefit packages. The database will contain information on service delivery implications, health workforce requirements and essential medicines and devices, with links to overall WHO recommendations and guidelines. The repository will be continuously updated to reflect the latest evidence. The global database will be accompanied by extensive guidance on how to carry out country local contextualization processes to drive country impact, building on existing WHO tools and expanding existing guidance further.

PROGRESSIVELY REALIZE THE PACKAGE OF ESSENTIAL SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS INTERVENTIONS AS PART OF UNIVERSAL HEALTH COVERAGE

Recognizing that countries are in different positions in terms of resources, capacity, and the policy and legal environment, the most realistic option is for countries to commit in principle to a comprehensive approach to SRHR by adopting the definition proposed by the Guttmacher–*Lancet* Commission, and to progressively realize this approach through a step-by-step expansion of provided interventions. Progressive realization implies that each country will chart its own path towards UHC and increase access to essential SRHR interventions incrementally, with health benefits packages reflecting available resources and national health priorities. Country health systems are at a varying level of development and it is therefore necessary to take a stepwise approach, often referred to as a phased approach. Priorities are determined for the near future and a selected set of interventions is offered to the entire population. Structures are then put in place for longer term progress in order to increase the number of interventions over time.

REGIONAL EXAMPLE



WEST AFRICA

IMPLEMENTING AN ESSENTIAL PACKAGE OF SRHR INTERVENTIONS AT NATIONAL SCALE THROUGH REFERRAL HEALTH FACILITIES

In order to improve equitable access to integrated sexual, reproductive, maternal and newborn health services (including emergency obstetric and newborn care – EmONC), six countries in West Africa (Benin, Côte d'Ivoire, Chad, Guinea, Senegal and Togo) have set up a national network of referral (EmONC) health facilities.

Using data on population density, health facilities (e.g. obstetric activity, human resources, equipment) and the quality of referral linkages between Basic and Comprehensive EmONC facilities, these countries have identified a number of referral health facilities that can provide quality integrated sexual and reproductive health (SRH) services within 1 or 2 hours' travel time for a large proportion of the population, as illustrated in the following table.

Country	All health facilities carrying out deliveries (maternity facilities)		Referral health facilities (EmONC health facilities)	
	Number of facilities	**Population coverage** (calculated with AccessMod)	**Number of facilities**	**Population coverage by integrated SRH services** (calculated with AccessMod)
Benin	N/A	N/A	111	84%*
Guinea	446	94%**	105	81%**
Senegal	596	94%**	142	92%**
Togo	N/A	N/A	69	80%*

*Within 1 hour's travel time.
**Within 2 hours' travel time.

These referral health facilities serve as platforms for the integration of SRH services at national scale. Countries can focus resources to ensure that they have the required infrastructure, equipment and human resources (especially the deployment of teams of midwives, who can provide most of the essential care for women and newborns[10]) for the provision of quality and respectful health care. The package of interventions provided in these facilities includes comprehensive maternal and newborn health care (including the seven Basic EmONC signal functions and caesarean section and blood transfusion for Comprehensive EmONC health facilities[11]); safe abortion services (to the extent of the law) and post-abortion care; counselling and services for a range of modern contraceptives; immunization; prevention and treatment of HIV infection and other STIs; and the prevention, detection and management of reproductive cancers (especially cervical cancer) and other maternal and reproductive health morbidities. These health facilities also support lower level health facilities to provide a package of integrated SRH services adapted to their infrastructure and in line with the competences of their staff.

The countries implementing this approach have (a) conducted a national assessment of referral (EmONC) health facilities; (b) engaged stakeholders supporting reproductive, maternal and newborn health; (c) analysed population data, health system resources (including human resources, equipment and supplies) and infrastructure, such as road networks; (d) defined the missions of the referral health facilities (Basic EmONC and Comprehensive EmONC health facilities) and resources required for delivering the defined package of SRH services; (e) identified the health facilities to include in the national network, focusing on those with the most important catchment areas and with the greatest potential to provide quality integrated SRH services; (f) defined key SRH indicators to be monitored on a quarterly basis as part of the health management information system; and (g) set up "implementation support teams" to help health facility and district staff analyse data and take actions to address gaps in availability and quality of care.[12]

10 UNFPA et al. (2014). *The State of the World's Midwifery (SoWMy) Report: A Universal Pathway. A Woman's Right to Health.* UNFPA.

11 WHO, UNFPA, UNICEF and AMDD (2009). *Monitoring Emergency Obstetric Care – A Handbook.* WHO.

12 *Improving Emergency Obstetric and Newborn Care (EmONC) – Implementation Manual for Developing a National Network of Referral Maternity Facilities.* UNFPA guidance document, 2019.

Progressive realization also includes taking action for legal and policy reform to improve the accessibility, availability, acceptability and quality of services. One essential legislative reform is to widen the grounds on which abortion is permitted. Reforming laws around abortion paves the way to train providers in safe abortion care, ensure access to safe methods and destigmatize the practice (Starrs and others, 2018). Other important legal reforms that need to be advanced as part of a comprehensive approach to SRHR are the prohibition of child marriage and female genital mutilation, ensuring adolescents' independent and autonomous access to SRHR, the prohibition of violence against women and changes to discriminatory laws directed at certain practices.

COUNTRY EXAMPLE

ETHIOPIA

POLITICAL COMMITMENT TO IMPLEMENT EVIDENCE-DRIVEN ACTIONS FOR BETTER MANAGEMENT OF HIGH-RISK UNWANTED PREGNANCIES

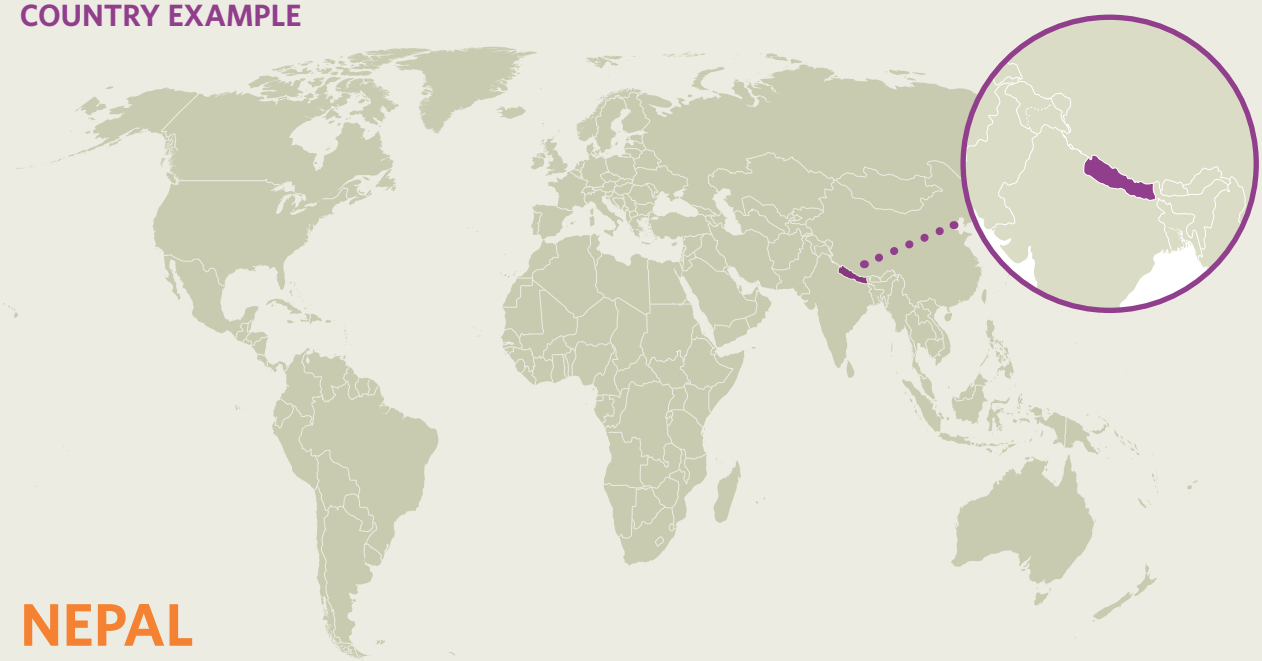
In most developing countries, poor management of high-risk unwanted pregnancies, in particular unwanted pregnancies among unmarried young girls and women, is one of the major causes of maternal mortality. Restrictive national abortion laws, policies and programmes have played a significant role in increasing the risks associated with unwanted pregnancies, and this in turn has contributed to maternal mortality.

The number of preventable maternal deaths in Ethiopia remained high until the first half of 2000 (there were 687 maternal deaths per 100,000 live births in 2005), with unsafe abortion accounting for nearly one-third of all maternal deaths. To address this situation, Ethiopia initiated an ambitious Health Extension Programme in 2003. The main objective of the programme was to rapidly scale up high-impact, proven and highly cost-effective sexual, reproductive, maternal, neonatal and child health services through community-based health extension workers. Along with the programme, the Federal Ministry of Health in Ethiopia initiated a nationwide dialogue on how to make the country's restrictive abortion law more appropriate for managing high-risk unwanted pregnancies.

The Ministry of Health used well-constructed health arguments and its political capital to enable better management of unwanted high-risk pregnancies to reduce the number of preventable maternal deaths. The Ministry was also able to secure full buy-in from the Office of the Prime Minister of Ethiopia. The Ministry of Health, with support from the Office of the Prime Minister and others, worked closely with all major political, cultural, social and religious influencers and opinion-makers to enable landmark abortion legislation to be passed in the Ethiopian parliament in 2005.

The 2005 abortion legislation permitted the use of safe abortion services in cases of rape, incest, fetal impairment, physical or mental disability of the woman, or pregnancy in minors. This legislation provided the necessary legal support to the Ministry of Health to expand high-quality comprehensive maternal health services. As a result of political commitment to implement evidence-driven legislation, policies and programmes, the management of high-risk unwanted pregnancies in Ethiopia has become legal and safer, contributing to a reduction in the number of maternal deaths (there were 353 maternal deaths per 100,000 live births in 2015, a decline of nearly 50 per cent compared with the number of deaths in 2005). Despite these positive developments, universal access to safe abortion and post-abortion care remains a challenge, and the Ministry of Health remains fully committed to addressing all legal, policy and programmatic challenges associated with the management of high-risk unwanted pregnancies.

COUNTRY EXAMPLE



NEPAL

ACCESS TO SAFE AND LEGAL ABORTION

The case of Nepal is instructive for a successful roll-out of safe legal abortion based on public health evidence-based policy-making. Legislation legalizing abortion was passed in 2002, resulting in a sharp decline in severe abortion complications and maternal mortality, which fell from 548 deaths per 100,000 live births in 2000 to 258 deaths per 100,000 live births in 2015 (Henderson and others, 2013; Nepal Ministry of Health,2002; WHO, 2015). The legislative change was the result of sustained advocacy work to raise awareness of the very high maternal mortality rate in Nepal, with many deaths occurring as a result of unsafe abortion (Henderson and others, 2013). The Safe Motherhood and Reproductive Health Rights Act of 2018 permits abortion up to 12 weeks' gestation on request and up to 28 weeks' gestation in cases of rape, incest or fetal abnormality or if the pregnancy poses a danger to the woman's life or physical/mental health.

Sustained, comprehensive and concerted planning efforts among a range of multisectoral stakeholders, coordinated by the Ministry of Health and Population, enabled Nepal to rapidly implement and scale up safe abortion services across all 75 districts of the country (Samandari and others, 2012). In 2014, about 1,100 government-approved health facilities provided legal abortion or post-abortion care (Puri and others, 2016). Government data indicate that the use of safe abortion care has been increasing since its legalization, with about 98,640 safe abortion service users in 2017/18 (Government of Nepal, Ministry of Health and Population, 2019). Post-abortion contraceptive use has also risen, with a rate of about 75 per cent in 2017/18 (Government of Nepal, Ministry of Health and Population, 2019). The Nepalese government has since made further commitments to expand access to SRHR, including safe abortion, through the above-mentioned legislation and the inclusion of safe abortion care in the National Family Planning Costed Implementation Plan (Government of Nepal, Ministry of Health and Population, 2015).

Abortion legalization marked a paradigm shift in Nepal. Abortion is constitutionally protected and women's reproductive rights, including the right to abortion, are now recognized as fundamental human rights (Supreme Court of Nepal, 2009). Despite these successes, women continue to face barriers to accessing safe abortion care, including lack of awareness of the legal status of abortion, often prohibitive care costs, geographic barriers and inequitable distribution of services, stigma and harmful gender norms (Puri and others, 2016; Wu and others, 2017). Nepal's legislative basis provides a strong foundation for additional actions aimed at tackling these barriers and to further advance social justice and equitable abortion access.

In line with the concept of progressive universalism, and in addition to addressing the SRHR needs of the population, countries need to focus on disadvantaged groups and marginalized populations with distinct needs or facing greater obstacles to accessing SRHR, such as people living in poverty, adolescents, migrants and refugees, racial and ethnic minorities, people with non-conforming sexual orientations and gender identities and people with disabilities.

Countries are encouraged to develop a roadmap for operationalizing a comprehensive approach to SRHR in which, ultimately, all interventions are provided for all people. Such a roadmap should be conceptualized with a life course perspective on SRHR, which is key for addressing gaps in both continuity of care and equity in access to essential sexual and reproductive health interventions. Excluding any of the essential interventions, either entirely or temporarily, in countries taking a progressive realization approach must be an informed choice.

REFERENCES

Campos, Nicole, and others (2012). Health and economic impact of HPV 16/18 vaccination and cervical cancer screening in Eastern Africa. *International Journal of Cancer*, vol. 130, pp. 2672–84.

Campos, Nicole, and others (2015a). Cervical cancer screening in low-resource settings: a cost-effectiveness framework for valuing tradeoffs between test performance and program coverage. *International Journal of Cancer*, vol. 137, pp. 2208–19.

Campos, Nicole, and others (2015b). The comparative and cost-effectiveness of HPV-based cervical cancer screening algorithms in El Salvador. *International Journal of Cancer*, vol. 137, pp. 893–902.

Campos, Nicole, and others (2015). When and how often to screen for cervical cancer in three low- and middle-income countries: a cost-effectiveness analysis. *Papillomavirus Research*, vol. 1, pp. 38–58.

Carvalho, Natalie, Ahmad Shah Salehi and Sue Goldie (2013). National and sub-national analysis of the health benefits and cost-effectiveness of strategies to reduce maternal mortality in Afghanistan. *Health Policy and Planning*, vol. 28, pp. 62–74.

Denny, Lynette, and others (2016). Interventions to close the divide for women with breast and cervical cancer between low-income and middle-income countries and high-income countries. *Lancet*, vol. 389, pp. 862–70.

Erim, Daniel, Stephen Resch and Sue Goldie (2012). Assessing health and economic outcomes of interventions to reduce pregnancy-related mortality in Nigeria. *BMC Public Health*, vol. 12, p. 786.

Ginsberg, Gary, and others (2012). Cost effectiveness of strategies to combat breast, cervical, and colorectal cancer in sub-Saharan Africa and South East Asia: mathematical modelling study. *BMJ*, vol. 344, p. e614.

Global Burden of Disease Health Financing Collaborator Network (2019). Past, present, and future of global health financing: a review of development assistance, government, out-of-pocket, and other private spending on health for 195 countries, 1995–2050. *Lancet*, vol. 393, pp. 2233–60.

Goldie, Sue, and others (2001). Policy analysis of cervical cancer screening strategies in low-resource settings. clinical benefits and cost-effectiveness. *JAMA*, vol. 285, pp. 3107–15.

Goldie, Sue, and others (2005). Cost-effectiveness of cervical-cancer screening in five developing countries. *New England Journal of Medicine*, vol. 353, pp. 2158–68.

Goldie, Sue, and others (2008a). Benefits, cost requirements and cost-effectiveness of the HPV16,18 vaccine for cervical cancer prevention in developing countries: policy implications. *Reproductive Health Matters*, vol. 16, pp. 86–96.

Goldie, Sue, and others (2008b). Health and economic outcomes of HPV 16,18 vaccination in 72 GAVI-eligible countries. *Vaccine*, vol. 26, pp. 4080–93.

Goldie, Sue, and others (2010). Alternative strategies to reduce maternal mortality in india: a cost-effectiveness analysis. *PLOS Medicine*, vol. 7, p. e1000264.

Government of Nepal, Ministry of Health and Population (2015). National Family Planning Costed Implementation Plan 2015–2020. Available from: http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/03/FP-Costed-Implementation-Plan-nepal.pdf (accessed 20 June 2019).

Government of Nepal, Ministry of Health and Population (2019). *Annual Report.* Department of Health Sciences 2074/75 (2017/18). Kathmandu.

Henderson, Jillian, and others (2013). Effects of abortion legalization in Nepal, 2001–2010. *PLOS ONE*, vol. 8, p. e64775.

Horton, Susan and Carol Levin (2016). Cost-effectiveness of interventions for reproductive, maternal, neonatal, and child health. In *Disease Control Priorities*, 3rd ed., vol. 2, *Reproductive, Maternal, Newborn, and Child Health: Disease Control Priorities*, Robert Black and others, eds. Washington, D.C.: International Bank for Reconstruction and Development and World Bank.

Hu, Delphine, and others (2007). The costs, benefits, and cost-effectiveness of interventions to reduce maternal morbidity and mortality in Mexico. *PLOS ONE*, vol. 2, p. e750.

Hu, Delphine, and others (2009). Cost-effectiveness analysis of alternative first-trimester pregnancy termination strategies in Mexico City. *British Journal of Obstetrics and Gynaecology*, vol. 116, pp. 768–79.

Hu, Delphine, and others (2010). Cost-effectiveness analysis of unsafe abortion and alternative first-trimester pregnancy termination strategies in Nigeria and Ghana. *African Journal of Reproductive Health*, vol. 14, pp. 85–103.

International Planned Parenthood Federation (2018). *IMAP Statement on Sexual and Reproductive Health Services in Humanitarian Settings.* IPPF London, UK.

Jit, Mark, and others (2014). Cost-effectiveness of female human papillomavirus vaccination in 179 countries: a PRIME modelling study. *Lancet Global Health*, vol. 2, pp. PE406–14.

Joint United Nations Programme on HIV/AIDS (2019). *Global Aids Update 2019.* Geneva, Switzerland.

Levin, Carol, and others (2010). Cost-effectiveness analysis of cervical cancer prevention based on a rapid human papillomavirus screening test in a high-risk region of China. *International Journal of Cancer*, vol. 127, pp. 1404–11.

Nepal Ministry of Health (2002). National safe abortion policy. Kathmandu. Available from: http://www.mohp.gov.np/images/pdf/policy/National abortion Policy.pdf (accessed 22 July 2019).

Patton, George, and others (2016). Our future: a *Lancet* Commission on adolescent health and wellbeing. *Lancet*, vol. 387, pp. 2423–78.

Praditsitthikorn, Naiyana, and others (2012). Economic evaluation of policy options for prevention and control of cervical cancer in Thailand. *Pharmacoeconomics*, vol. 29, pp. 781–806.

Prinja, Shankar, and others (2015). Costs, effectiveness, and cost-effectiveness of selected surgical procedures and platforms. In *Disease Control Priorities*, 3rd ed., vol. 1, *Essential Surgery*, Haile Debas and others, eds. International Bank for Reconstruction and Development and World Bank. Washington, DC.

Puri, Mahesh, and others (2016). Abortion incidence and unintended pregnancy in Nepal. *International Perspectives on Sexual and Reproductive Health*, vol. 42, pp. 197–209.

Samandari, Ghazaleh, and others (2012). Implementation of legal abortion in Nepal: a model for rapid scale-up of high-quality care. *Reproductive Health*, vol. 9, p. 7.

Singh, Susheela and Isaac Maddow-Zimet (2016). Facility-based treatment for medical complications resulting from unsafe pregnancy termination in the developing world, 2012: a review of evidence from 26 countries. *British Journal of Obstetrics and Gynaecology*, vol. 123, pp. 1489–98.

Singh, Susheela, Jacqueline Darroch and Lori Ashford (2014). *Adding It Up. The Costs and Benefits of Investing in Sexual and Reproductive Health 2014.* Guttmacher Institute, New York.

Singh, Susheela, and others (2018). *Abortion Worldwide 2017: Uneven Progress and Unequal Access.* Guttmacher Institute, New York.

Starrs, Ann, and others (2018). Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher–*Lancet* Commission. *Lancet*, vol. 391, pp. 1642–92.

Sundewall, Jesper (2019). UHC as a means to advance sexual and reproductive health and rights: Lessons from health benefits packages and prioritization processes in six countries in sub-Saharan Africa.

Supreme Court of Nepal (2009). *Lakshmi Dhikta v. Nepal (2009).* Available from: https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Lakshmi Dhikta - English translation.pdf (accessed 20 June 2019).

United Nations (2000). *Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights.* General Comment No. 14. United Nations Economic and Social Council.

United Nations Educational, Scientific and Cultural Organization (2015). *Emerging Evidence, Lessons and Practice in Comprehensive Sexuality Education – A Global Review.* Paris.

United Nations Educational, Scientific and Cultural Organization (2018). *International Technical Guidance on Sexuality Education. An Evidence-informed Approach.* Paris.

United Nations High Commissioner for Refugees (2019). *Global Trends: Forced Displacement in 2018.* Geneva, Switzerland.

United Nations Population Division (2009). *What Would It Take to Accelerate Fertility Decline in the Least Developed Countries?* Policy Brief 2009/1. New York.

United Nations Population Fund (2014). *Programme of Action of the International Conference on Population Development.* 20th anniversary edition. New York.

United Nations Population Fund (2019). *State of World Population 2019: Unfinished Business The Pursuit of Rights and Choices For All.* New York.

Vlassoff, Michael, and others (2009). Benefits of meeting the contraceptive needs of Ugandan women. *Issues Brief (Alan Guttmacher Institite)*, vol. 4, pp. 1–8.

Watkins, David, and others (2017). Universal health coverage and essential packages of care. In *Disease Control Priorities*, 3rd ed., *Improving Health and Reducing Poverty*, Volume 9, Dean Jamison and others, eds. Washington, D.C.: International Bank for Reconstruction and Development and World Bank.

Woog, Vanessa and Anna Kågesten (2017). *The Sexual and Reproductive Health Needs of Very Young Adolescents Aged 10–14 in Developing Countries: What Does the Evidence Show?* Guttmacher Institute, New York.

World Health Organization (2004). *Reproductive Health Strategy.* Geneva.

World Health Organization (2007). *Everybody's Business – Strengthening Health Systems to Improve Health Outcomes. WHO's Framework for Action.* Geneva.

World Health Organization (2015). *Trends in Maternal Mortality: 1990 to 2015.* Geneva.

World Health Organization (2017a). Human rights and health. Available from: https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health (accessed 24 September 2019).

World Health Organization (2017b). *Sexual Health and its Link to Reproductive Health: An Operational Approach.* Geneva.

World Health Organization (2018). *2018 Global Reference List of 100 Core Health Indicators (Plus Health-related SDGs).* Geneva.

World Health Organization Regional Office for Europe (2016). *Action Plan for Sexual and Reproductive Health: Towards Achieving the 2030 Agenda for Sustainable Development in Europe – Leaving No One Behind.* Copenhagen.

World Health Organization, Office of the United Nations High Commissioner for Human Rights (2007). The right to health. Fact sheet no. 31. Available from: https://www.ohchr.org/Documents/Publications/Factsheet31.pdf (accessed 24 June 2019).

Wu, Wan-Ju, and others (2017). Abortion care in Nepal, 15 years after legalization. Gaps in access, equity and quality. *Health and Human Rights*, vol. 19, pp. 221–30.

ANNEX 1:

INTEGRATED DEFINITION OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

DEFINITION OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS PROPOSED BY THE GUTTMACHER –*LANCET* COMMISSION (STARRS AND OTHERS, 2018)

Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction , not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in the promotion of self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when and who to marry;
- decide whether, when and by what means to have a child or children, and how many children to have;
- have access over their lifetime to the information, resources, services and support necessary to achieve all of the above, free from discrimination, coercion, exploitation and violence.

Essential sexual and reproductive health services must meet public health and human rights standards, including the availability, accessibility, acceptability and quality" framework of the right to health. The services should include:

- accurate information and counselling on sexual and reproductive health, including evidence-based CSE;
- information, counselling and care related to sexual function and satisfaction;
- the prevention, detection and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth and postnatal care;
- safe and effective abortion services and care;
- the prevention, management and treatment of infertility;
- the prevention, detection and treatment of STIs, including HIV infection, and of reproductive tract infections; and
- the prevention, detection and treatment of reproductive cancers.

www.unfpa.org

United Nations Population Fund
605 Third Avenue
New York, NY 10158
Tel. +1 212 297 5000