



Why sexual and reproductive health and rights are essential for universal health coverage



Purpose:

This brief calls for the accelerated prioritization, financing and implementation of comprehensive sexual and reproductive health and rights (SRHR) in national universal health coverage (UHC) plans.

Background

The world has committed to achieving universal health coverage (UHC) by 2030, as agreed in the UHC Political Declaration adopted by UN Member States in 2019 and in Sustainable Development Goal (SDG) 3.8.

UHC means that all individuals and communities have access to and receive the safe, effective, high-quality health services and care they need without suffering financial hardship.

The equitable provision of comprehensive sexual and reproductive health (SRH) services is a critical prerequisite for achieving UHC, as articulated in SDG 3.7 and 5.6, and article 68 of the UHC Political Declaration.

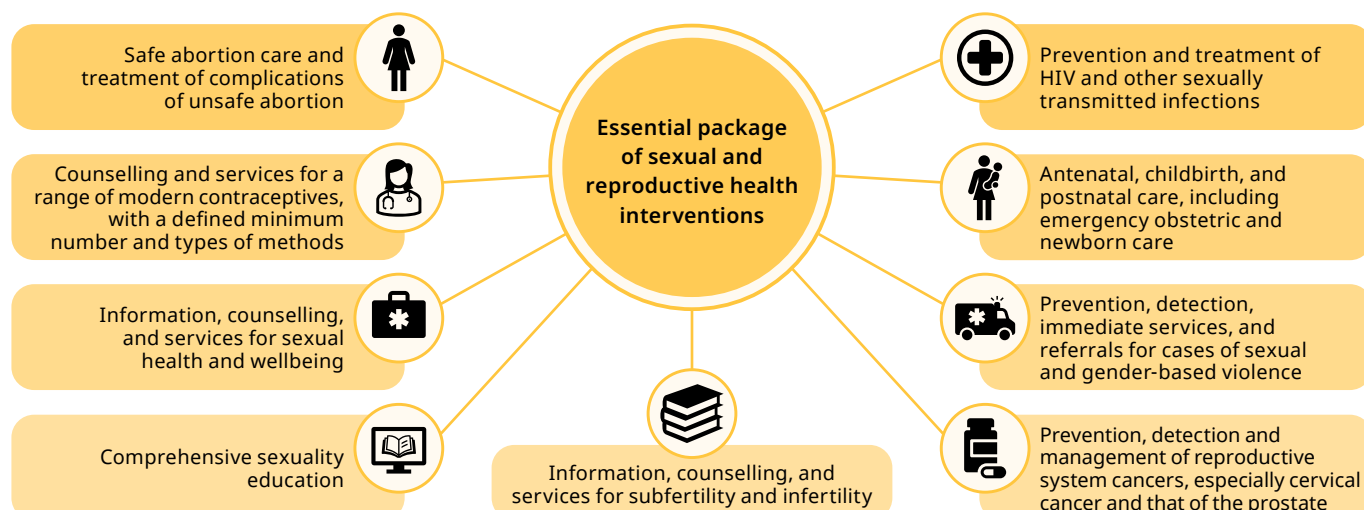
As well as being essential for women's and girls' health, sexual and reproductive health and rights (SRHR) lies at the core of sustainable development and is intimately linked to gender equality, education, employment, sustainable and inclusive economic growth, and poverty eradication.

Gender inequality is at the root of poor health outcomes for women and girls. Lack of agency and resilience, experience of discrimination, exposure to violence, inadequate SRHR information and inequitable access to a full range of SRH services all contribute to unacceptable rates of maternal mortality and unintended pregnancies. Implementation of comprehensive SRHR at a global level relies on comprehensive, rights-based and multisectoral approaches to services and interventions.

Defining SRHR from a life course perspective, the [2018 Guttmacher-Lancet Commission](#), building on WHO recommendations, proposed a comprehensive definition and essential package of nine SRH interventions for all people, everywhere.

The vast majority of **SRH services can and should be provided through primary health care (PHC)**, by both public and private sector channels. To aid implementation of comprehensive SRH interventions in UHC, WHO has developed a [guidance note](#) to aid stakeholders in navigating the SRH interventions with the [WHO UHC Compendium](#).

2018 Guttmacher-Lancet Commission, Essential package of SRH interventions



Benefits of investing in SRHR

The investments needed to achieve universal SRH provision are modest and affordable. **Fully meeting all women's needs in low- and middle-income countries (LMICs) for essential SRH services would cost as little as US\$ 10.60 per capita annually.**

SRHR is important at every age and investments in SRH services reap enormous returns in both the short and long terms.

Contraceptive services yield cost savings

Every \$1 spent on contraceptive services beyond the current level would save \$3 in the cost of maternal, newborn and comprehensive abortion care **because use of contraceptives reduces the number of unintended pregnancies.**



Specifically, investment in adolescent SRHR makes sound economic sense because those investments **yield a triple dividend of benefits**: for adolescents now, in their future adult lives and for the next generation. Unintended pregnancies would drop by six million if adolescent women's needs for modern contraceptives were met in LMICs.

Case study: Return on investment on health package for adolescents



An analysis across 40 LMICs highlighted that providing a package of 66 essential health care interventions – including essential SRH services – at a cost of about US\$ 4.60 per capita per year, would yield more than 10 times as much in benefits to society.

Why is urgent action needed?

Lack of comprehensive coverage of all SRH services

Great progress has been made over the last 30 years in increasing access to SRH interventions especially for family planning, and maternal and newborn care. This was achieved through the bold commitments and action of leading stakeholders in support of SRH within key international frameworks, including the International Conference on Population and Development (ICPD) Programme of Action, the Beijing Platform for Action, the Millennium Development Goals (MDGs) and the SDGs.

However not all SRH interventions have received the same support and **there is variation in degrees of integration, quality, coverage and prioritization of some SRH services.**

Almost 4.3 billion people of reproductive age do not have access to even one essential reproductive health intervention over the course of their lives.

Comprehensive SRH services are often omitted from national health strategies or benefit packages. Safe abortion and post-abortion care, comprehensive sexuality education (CSE), prevention and treatment of gender-based violence, family planning products and technologies, and fertility care are among the services most excluded from publicly funded schemes. Reasons for their exclusion include:

- Gender-based discrimination that influences how policy-makers and governments address SRHR and determine access to critical services, especially for adolescents.
- Social norms and attitudes that stigmatize certain services (e.g. CSE) or access to services by certain populations (e.g. adolescents, LGBTIQ+).
- Prohibitive or restrictive national laws and policies such as criminalization of abortion or lack of services for LGBTIQ in settings where same-sex relationships are illegal.

Case study: Lessons learned from COVID-19

Increased incidence of gender-based violence and heightened demand for emergency shelter was reported during the pandemic. Many countries failed to classify appropriate services for SRH, intimate partner violence and sexual violence as essential, in line with international human rights law. This compounded barriers faced by women and girls in accessing such services during the COVID-19 pandemic.



Strong evidence and guidance exist to steer what needs to be done to ensure everyone's right to comprehensive SRH services. However, this has been hard to achieve due to the lack of:

- SRHR advocates meaningfully participating in country UHC discussions;
- Disaggregated data on the SRHR needs of vulnerable communities to bridge the equity gap; and
- Transparent mechanisms and processes for priority setting and resource allocation.

As a result, SRHR advocates are concerned that sufficient progress will not be made to achieve the SDGs by 2030.

Equity in SRHR delivery is needed

SRH coverage and use is neither equal nor universal. Large

inequities exist both within and between countries including for vulnerable populations, not least adolescents.

Adolescent girls in LMICs have an estimated **21 million pregnancies** each year, **50% of which are unintended.**



Country case study: Tune Me in Zambia

UNFPA has worked with partners to develop **Tune Me**, a mobile site that provides accurate and age appropriate SRHR information and services to young people in seven African countries. It aims to reduce teenage pregnancies and HIV incidence, promote safer behaviours and equip young people with skills to make more informed decisions about their health.

In Zambia, Malawi and Uganda across 2016-2019, Tune Me had over **2.8 million users** and showed promising results with a 30% increase in the number of users who began accessing SRHR services after joining. Increase was also seen in the frequency of users accessing HIV testing and in condom use.

In Zambia, a sustainability strategy was incorporated during the early phases of development with the ultimate goal of transferring ownership of the programme to the government. The platform is now jointly owned by Zambia's Ministry of Youth Sport and Child Development and the Ministry of Health who have allocated staff to review content and ensure alignment with the latest national strategies and guidelines as well as maintaining and managing the site. Transitioning programme ownership to Zambia's national government has enabled the long-term sustainability of the work.

Cost of services is a key driver of inequity. Often, the people most affected by informal out-of-pocket health expenditure are already in vulnerable situations due to systemic inequalities.

Free point-of-care access to SRHR is critical to achieving UHC. However, severe funding gaps for SRH services persist through a combination of insufficient funding allocations, inefficient government spending and fluctuations in external funding from donors. This is particularly challenging in LMICs which carry the highest health burden of maternal mortality and are most dependent on external donor funding for SRH services.

Reproductive health services in LMICs **account for just 9% of global donor funding for health**.

To accelerate equitable and sustainable progress towards UHC, health services should be funded predominantly through domestic public funding that combines taxes and prepayment mechanisms. Increased domestic funding for SRHR can also incentivise additional external investments, including from donors and the private sector. Greater impact can also be achieved through improving the efficiency and equity in the allocation of domestic investments.

In addition, approaches to delivering SRHR must meet the needs of the most vulnerable communities. Specifically for adolescents, use of innovative digital approaches can increase the reach of SRH services and promote self-care. As these approaches become more widespread, mechanisms to ensure their quality and accessibility will be essential.

Need for sustained and continued investment in SRHR during emergencies

The world is being impacted by more and more crises including ensuing and worsening conflicts, the ongoing food and nutrition crisis and the unfolding climate emergency. Such crises exacerbate existing inequalities with women, girls and vulnerable groups suffering disproportionately, both directly from the emergency itself, and from the increased risk of sexual violence, gender-based violence, early marriage, and human trafficking.

In humanitarian and conflict settings (2021)



1/3 girls reported that their first sexual experience was forced



97% of conflict related sexual violence cases reported were violence against women and girls (VAWG).

Whilst SRH services were interrupted and impacted by the COVID-19 pandemic, in some settings **barriers to accessing services were successfully mitigated through innovative digital self-care approaches, task-sharing arrangements and socio-political commitments to prioritize and finance sustained service delivery**. It is crucial that these approaches be sustained.

Country case study: Bangladesh's Essential Service Package

The Government of Bangladesh established the **Essential Service Package (ESP)** in 1998 as part of its sector-wide approach programme with two subsequent revisions made to reflect changing needs and priorities. The holistic package has been implemented by both public and not-for-profit providers. Critically, the latest version of the package includes all nine essential SRH services within the Guttmacher-Lancet Commission Report. Bangladesh has made remarkable progress in reducing neonatal and maternal mortality and is **on track to meet the related SDGs targets by 2030**. Data has shown that the country's interventions have resulted in a 31.5% decrease in the rate of maternal mortality and a 58.4% of neonatal mortality rate between 2000-2020.

Levers for success in implementation of this Essential Package of care include:

- Utilization of information and communication strategies to improve population coverage;
- Decentralization of care from hospital to household visits;
- Restructuring of government sectors which allowed, for example, the family planning directorate of the Ministry of Health and Family Welfare to engage in SRH; and
- Increased focus on quality of services.

Asks to key stakeholders

Every stakeholder has a role to play in fully realizing people's SRHR as part of approaches to achieving UHC. The table below sets out the steps that each stakeholder group should take.

STAKEHOLDERS	RECOMMENDED ACTIONS
Governments and parliamentarians 	• Ensure the progressive realization, with deliberate and continual progress on the status, of SRHR in national UHC plans through sufficient domestic financial allocations for universal access to comprehensive SRH services. • Improve alignment and coordination across governments and other stakeholders on SRHR policies and financing. • Meaningfully engage with SRHR advocates, communities and civil society (including feminist and women- and youth-led organizations) for the design, implementation and monitoring of rights-based SRH and UHC services. • Implement comprehensive packages of quality essential SRH services and comprehensive sex education in schools that recognize the specific needs of vulnerable populations including adolescents; are integrated with existing health systems (including PHC and community health systems); and are universally available to all and sustained during emergencies. • Enact progressive policies and legislation related to support the expanded provision of quality essential SRH services and SRHR, and the regulation of private providers. • Hold governments and other stakeholders to account for progress towards SRHR and UHC targets.
Donors and foundations 	• Include SRHR as an integral part of UHC efforts and protect health investments among other emerging priorities, ensuring equitable access to an essential package of health interventions. • Support evidence-based action for investing in SRH services and interventions.
United Nations 	• Ensure robust and timely monitoring, for example through SDG Voluntary National Reviews, of trends, national health system needs, resource flows and readiness to provide and implement SRH services. • Strengthen efforts to disaggregate data by gender and other key equity indicators. • Increase cross-agency collaboration to ensure the development of normative guidance, technical tools and capacity building tools to support the implementation of SRHR within national UHC plans. • Work with Member States to implement WHO guidance on integration of SRH interventions in UHC strategies.
Private sector 	• Develop and upscale innovations and digital solutions at the country level that strengthen health and community systems, address inequities and deliver available, accessible, acceptable, affordable, quality essential healthcare, which includes SRHR, to all. • Work with governments to implement innovations and develop mechanisms to evaluate effectiveness and reach. • Engage with the public health sector to build innovative and collaborative health system arrangements that improve efficiency in financial allocation to services, optimize SRHR service delivery and expand the reach of national health insurance plans and services.
Academic and research institutes 	• Generate and synthesize participatory evidence to understand the levers for success and failure of national policies and strategies for quality SRHR provision, especially following global and local emergencies. • Strengthen the evidence base on the impact of health financing reforms on access to SRH services and on health outcomes. • Establish strong links to key decision makers to support the use of evidence for developing SRHR policies. • Identify needs in SRH service coverage and use in vulnerable populations, including those in conflict and/or crisis settings. • Generate estimates of the potential health and economic benefits of SRHR investments, and of covering SRHR in national health plans.
Civil society organizations (CSOs) 	• Capture and amplify lived experiences and voices from communities to help shape policies and programmes, including women's and youth movements to highlight the current status of SRH coverage particularly for vulnerable communities including adolescents. • Strengthen community awareness of the importance of SRHR in UHC schemes and the benefits of SRH services to increase service uptake, reduce stigma, provide better quality of care, and make more efficient use of health system resources. • Contribute to and/or lead on the delivery of a full range of essential SRH services at community and primary care levels. • Ensure accountability on SRHR and UHC commitments by governments.
Health care professional associations (HCPAs) 	• Provide non-stigmatizing, non-discriminatory services and treat service users with dignity and respect to improve access to high quality services. • Instil regulated and continuous training and education for providers including midwives and nurses so they have the skills and competencies to provide high quality SRH services.

Photo credits: cover page, Flickr Creative Commons License/Dining for Women; page 2 (left), © WHO/Blink Media - Etinosa Yvonne; page 2 (right), © WHO. Design: Annovi Design.



THE AGA KHAN UNIVERSITY

