

Critical considerations
and actions for **achieving
universal access to sexual
and reproductive health**
in the context of universal health
coverage through a primary health
care approach



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Foreword

Half of the world's population lacks access to essential health services, and about 500 million have been pushed into extreme poverty because of catastrophic health expenses. This situation has been exacerbated by the COVID-19 pandemic.

WHO has committed itself to contributing to the efforts of its Member States to achieve the targets of health-related Sustainable Development Goals (SDG), including those on sexual and reproductive health (SRH) and universal health coverage (UHC). Primary Health Care (PHC) is a cornerstone of sustainable health systems for the achievement of UHC and the health-related SDGs, and the majority of SRH services can be provided through PHC.

Progress towards integrating SRH in the context of UHC and PHC requires a combination of political commitment and well-defined and coherent strategies for ensuring success. This document responds to the need for evidence-based strategies that can be implemented to ensure effective and efficient integration of SRH services within national PHC strategies to advance progress towards UHC.

This practical tool will be helpful for decision-makers, programme managers and implementers, civil society, researchers, and wider health systems communities. It covers guidance for the inclusion of comprehensive SRH services in health benefit packages, planning and implementation of integrated packages of SRH services, as well as accountability processes and measures for ensuring universal access to all essential SRH services.

The document also showcases innovative examples from a range of countries of the ways in which SRH services have been integrated in national PHC strategies to advance progress towards UHC, demonstrating both variations across countries in terms of economic, social and cultural contexts that influence access to SRH services, but also generic lessons that can be applied in virtually all contexts. We urge all stakeholders and the wider health systems communities working towards ensuring sexual and reproductive health and rights (SRHR) through PHC for achievement of UHC to put these considerations into practice.

A key message throughout this document is that progress towards universal access to SRH services depends on the meaningful participation of intended beneficiaries in every aspect of planning, implementation, monitoring and accountability. Listening and responding to the voices of those most left behind is essential and mechanisms to enable participation and voice must be integral to all national efforts. Acting together, everyone concerned with achieving universal access to SRH services through strengthened PHC systems can benefit from the evidence and lessons outlined in this guidance document.



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Abbreviations

AIDS	Acquired immunodeficiency syndrome
CSO	Civil society organization
EMTCT	Elimination of mother-to-child transmission
GBV	Gender-based violence
HBP	Health benefit package
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
ICPD	International Conference for Population and Development
ICPD PoA	International Conference for Population and Development Programme of Action
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex, or questioning
M&E	Monitoring and evaluation
NGO	Nongovernmental organization
NHSO	National Health Security Office
P4P	Pay for performance
PHC	Primary health care
PPC	Postpartum care
SARA	Service availability and readiness assessment
SDG	Sustainable Development Goals
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SRMNCAH	Sexual, reproductive, maternal, newborn, child and adolescent health
STI	Sexually transmitted infection
UHC	Universal health coverage
UNICEF	United Nations Children's Fund
UPR	Universal Progress Reviews
WHO	World Health Organization
VAW	Violence against women



PART A: Overview and background



Overview



Objective: to provide guidance to WHO Member States



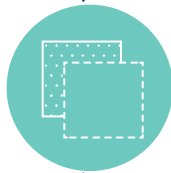
Target audience: stakeholders, including high-level decision-makers; and wider health systems communities



Structure: policy and operational actions from planning through to accountability



Methodology: developed through a process that included technical expert consultations, scoping review and country case studies



Background



Achieving universal access to sexual and reproductive health in the context of primary health care and universal health coverage



The centrality of a comprehensive approach to sexual and reproductive health and rights

Overview

Objective

The objective of *Critical Considerations and Actions for Achieving Universal Access to Sexual and Reproductive Health in the Context of Universal Health Coverage through a Primary Health Care Approach* is to provide guidance to WHO Member States for ensuring progress towards universal access to comprehensive sexual and reproductive health (SRH) in the context of primary health care (PHC)- and universal health coverage (UHC)-related policy and strategy reforms.

Target audience

Critical Considerations and Actions is intended for stakeholders working towards ensuring universal access to SRH services within individual country programmes especially in the context of UHC strategies. These stakeholders include high-level decision-makers responsible for setting policies, strategies and plans and for developing budgets for PHC and SRH services at national and subnational levels. Critical Considerations and Actions is also designed to support wider health systems communities: specialists in health financing; gender specialists; health insurance authorities; national statistical offices; monitoring specialists; advocates, researchers, consultants and civil society organizations active in sexual and reproductive health and rights (SRHR); and private sector partners.

Structure

The structure and content of Critical Considerations and Actions is informed by and adapted from:

- The Reproductive Health Strategy to Accelerate Progress Towards the Attainment of International Development Goals and Targets Related to Reproductive Health (1), also known as the WHO Reproductive Health Strategy;
- The Operational Framework for Primary Health Care: transforming vision into action (2); and
- Strategizing National Health in the 21st Century: a handbook (3).

The WHO Reproductive Health Strategy, which recognizes the crucial role of SRH in social and economic development in all communities, calls for action in five key areas:

- 1 strengthening the capacity of health systems;
- 2 improving information for priority setting;
- 3 mobilizing political will;
- 4 creating supportive legislative and regulatory frameworks; and
- 5 strengthening monitoring, evaluation and accountability.

The strategy also urges WHO Member States to make SRH a central element of their national planning and strategy development processes.

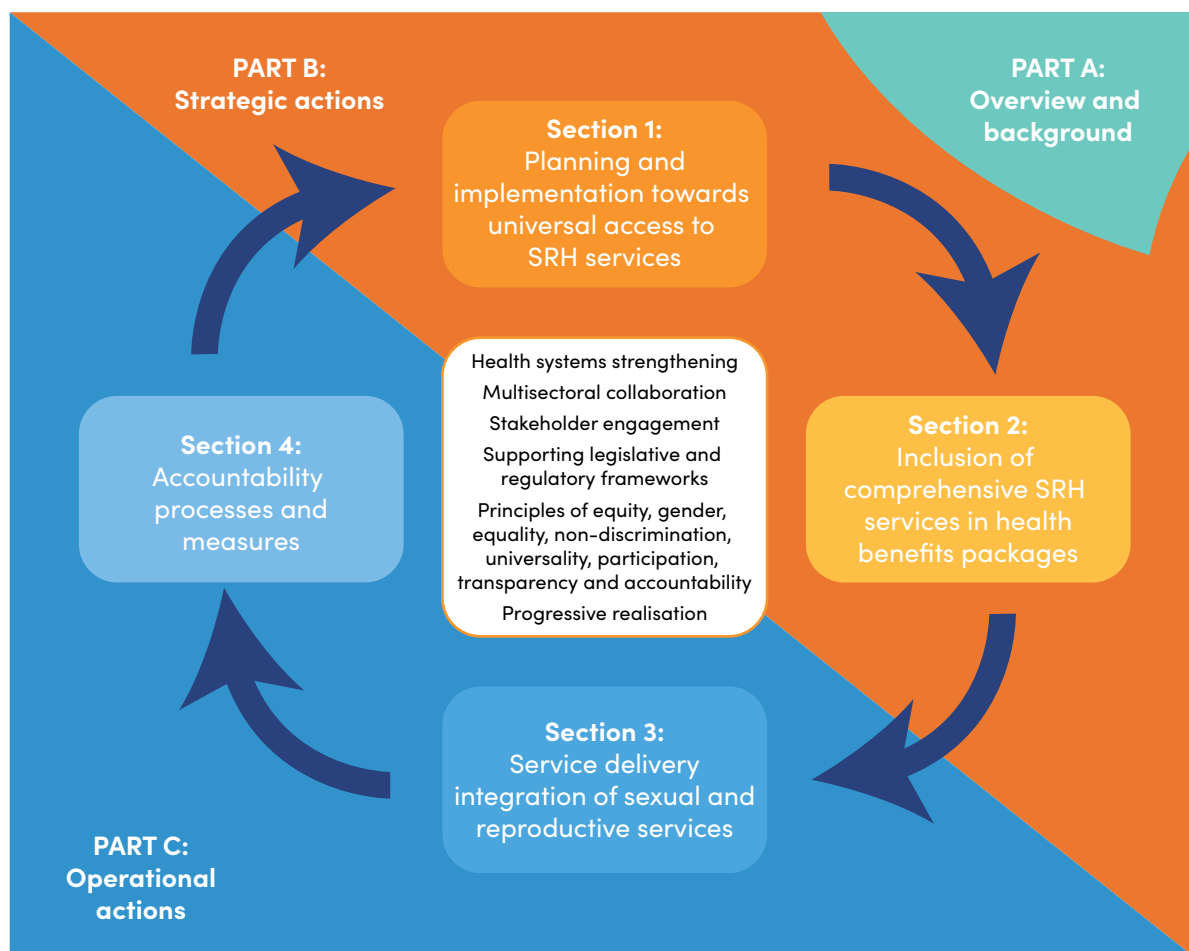
The WHO Handbook on Strategizing National Health in the 21st Century is a normative guide which offers a framework for and practical guidance to countries addressing the most critical issues in national health policy and planning towards UHC (3).

The Operational Framework for Primary Health Care is a reference guide for how countries can strengthen PHC towards UHC (2). It identifies 14 levers for action (such as strategic and operational) to improve PHC. These levers expand on the building blocks of health systems to identify key elements of those health system that can be used to accelerate progress in PHC across programmes and services including in SRH. These essential building blocks include a health workforce, medicines and technologies, information systems, service delivery, financing and governance (4). The Operational Framework additionally provides, for each lever, a list of actions and interventions that can be applied at policy and operational levels.

This document is organized in three parts covering four sections (see Figure 1).

- **Part A** provides an overview and background to the guidance document.
- **Part B:** Core Strategic Actions to Achieve Universal Access to Comprehensive Sexual and Reproductive Health Services covers:
 - **Section 1:** Planning and Implementation Towards Universal Access to SRH Services provides guidance on planning and implementation of national health policies and strategies; and
 - **Section 2:** Inclusion of Comprehensive Sexual and Reproductive Health Services in Health Benefit Packages Towards Universal Health Coverage, presents key policy actions for ensuring that SRH services are comprehensively integrated within health benefit packages.
- **Part C:** Actions at Operational Level covers:
 - **Section 3:** Service Delivery Integration of Sexual and Reproductive Health Services in Universal Health Coverage and Primary Health Care Contexts, provides guidance on and considerations for delivering integrated SRH service delivery within the broader health system oriented towards PHC; and
 - **Section 4:** Accountability Processes and Measures for Ensuring Universal Access to Comprehensive Sexual and Reproductive Health Services. This outlines guidance on key elements for the design and implementation of accountability processes and measures to drive and monitor progress on the implementation of national SRH policies and strategies and commitments in UHC and PHC contexts.

Figure 1: Key considerations for advancing universal access to comprehensive sexual and reproductive health services



Methodology

These Critical Considerations and Actions were developed through a process that included a scoping review, technical expert consultations and an evaluation of country case studies.

The scoping review explored the literature on universal coverage of SRH services within the context of UHC, to synthesize what is known and to identify the gaps in this knowledge. The topics included financing of SRH services, inclusion of SRH services in health benefit packages, the role of the private sector in expanding population and service access to SRH services, service delivery challenges, gender-based barriers, rights violations and accountability mechanisms.

Three technical consultations involving country programme managers, researchers, representatives of civil society organizations (CSOs), WHO regional and country offices and other relevant WHO departments were held. A core working group, comprising internal and external scientists and participants of the technical consultative meetings, contributed to developing the content of this handbook and ensured the rigorous technical review of several interim drafts.

The primary purpose of the case studies, using a health policy analysis framework, is to inform users of the guide of the process and actions taken by the selected countries towards ensuring the inclusion of SRH in national health policies and strategies.

Background

Achieving universal access to sexual and reproductive health in the context of primary health care and universal health coverage

Half of the world's population lacks access to essential health services, and about half a billion have been pushed into extreme poverty because of catastrophic health expenses (5). This is compounded for those populations that are particularly vulnerable, and marginalized groups that face multiple forms of discrimination and inequalities.

Universal health coverage means, "all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course" (6). The World Health Organization is actively supporting its Member States to achieve Sustainable Development Goals (SDG) target 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).

Reproductive and sexual health were first defined at the 1994 International Conference for Population and Development (ICPD) (see Box 1).

Box 1: Defining reproductive and sexual health, and essential sexual and reproductive health services

Defining reproductive and sexual health

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases (7).

Defining essential sexual and reproductive health services

While there is no universal agreement on which health care services are needed to enable people to fulfil their right to the highest standard of sexual and reproductive health, in 1994 the International Conference for Population and Development Programme of Action (ICPD PoA) identified many of the services that are today considered essential. WHO's Reproductive Health Strategy (agreed upon by a World Health Assembly Resolution in 2004) draws upon the ICPD PoA conceptualization of SRH and provides clear recommendations for the services that are needed for national programmes to address the five core aspects of reproductive and sexual health: "improving antenatal, perinatal, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health" (1). The Guttmacher-Lancet Commission on SRHR (8) provides a similar definition of the services that should be provided for achieving SRH: "comprehensive sexuality education; counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods; antenatal, childbirth and postnatal care, including emergency obstetric and newborn care; safe abortion services and treatment of complications of unsafe abortion; prevention and treatment of HIV and other sexually transmitted infections; prevention, detection, immediate services 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" (8).

The ICPD PoA and SDGs both link sexual and reproductive health to the human rights of individuals and couples to decide on the number, spacing and timing of their children and being free to make reproductive choices without fear of

discrimination, coercion or violence (7,9). Moreover, in its Thirteenth General Programme of Work, WHO commits itself to contributing to national efforts to achieve both target 3.7 of the SDG Goal 3 on Health, and target 5.6 of SDG Goal 5 on Gender Equality.

Box 2: Sustainable Development Goals, targets 3.7 and 5.6

Goal 3. Target 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.

Goal 5. Target 5.6: ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the ICPD PoA and the Beijing Platform for Action and the outcome documents of their review conferences.

PHC is “a whole-of-society approach” to health that aims to maximize the level and distribution of health and well-being through three components (2):

- (a) primary care and essential public health functions as the core of integrated health services;
- (b) multisectoral policy and action; and
- (c) empowered people and communities”.

PHC was identified as key to the attainment of the goal of Health for All (10) in the Global Conference at Alma Ata in 1978. The global health community reaffirmed its commitment to PHC as a cornerstone of sustainable health systems for the achievement of UHC and the health-related SDGs in 2018 at the 40th anniversary of the Alma Ata Conference. Numerous comparative analyses of health systems have demonstrated that PHC is the most equitable, efficient and effective strategy to enhance the health of populations (11).

In many countries, high, middle and low-income, SRH services are critical components of PHC. This centrality of PHC for SRH was recognised by the 1994 ICPD, which called upon member states to make SRH services accessible through PHC by 2015 (7,12). PHC is a platform for UHC in every health system, providing a platform for integrating previously separate services with those for women’s, children’s and adolescents’ health (9).

The global commitment to and increasing momentum towards UHC have increased the focus on the role of explicit health benefit packages as a cornerstone of progress towards achieving UHC and PHC goals of improved access, equity, financial protection, efficiency and quality care. It should be noted that most, if not all, countries do already have a health benefit package arrangement in place, although there is great variation in the range of SRH services included, the populations covered and the ways in which they are funded and function.

Not all countries will be able to integrate all these SRH services into their health benefit packages in the context of UHC, at least not initially. Therefore, prioritization of the services with the most impact while leaving no-one behind, and “progressive realization” to achieve comprehensive sexual and reproductive health will be needed (8,13). Most Member States are at different stages with respect to progress towards UHC generally and towards universal access to comprehensive rights-based SRH services specifically. These countries also vary widely in terms of gendered social and cultural contexts that influence the availability of and access to SRH services and economic, political and health systems which have a bearing on progress towards UHC, including which services are already available and accessible, at what cost, and to whom.

Box 3: Global guidance on integrating sexual and reproductive health services within national universal health coverage strategies and plans, and health benefit packages

WHO's [UHC Compendium of Health Interventions](#) and the [comprehensive SRH services in it](#) are important resources to support the deliberative processes for countries developing a new or adjusting an existing health benefit package.

The WHO UHC Compendium of Health Interventions was launched in 2020. It supports linkages across the various levels of health systems to facilitate integrated service delivery. This guidance should be considered alongside a review of the extent of inclusion of comprehensive SRH services within health benefit packages. In instances when services are excluded, the reasons should be identified (see Annex 1) since this will help to determine the appropriate action and steps towards future inclusion in health benefit packages.

The SRH interventions in this Compendium are aligned with the WHO Reproductive Health Strategy, the WHO Framework for Operationalizing Sexual Health and its Linkages to Reproductive Health and the report of the Guttmacher–Lancet Commission on SRHR. The intervention categories include antenatal care, labour and childbirth care, postnatal care, contraception and family planning, infertility, sexual health, female genital mutilation (FGM), intimate partner and sexual violence, comprehensive sexuality education, abortion, ectopic pregnancy, HIV, sexually transmitted infections and cancers (such as, breast, cervical, prostate, ovarian, uterine).

The centrality of a holistic approach to sexual and reproductive health and rights

Deep-rooted inequalities and asymmetries in gender and social norms are often at the root of the neglect of the health of vulnerable groups. Moreover, effective prevention of gender-based violence necessitates interventions from multiple sectors beyond health. Elderly people, migrants, ethnic minorities and refugee and mobile populations are at risk of continued exclusion from services and of receiving poor-quality treatment. Discrimination and bias manifested in the choices, advice and quality of care available further exacerbate poor sexual and reproductive health-seeking behaviours, while violating a number of rights (14). The very nature of SRHR requires that they are understood and upheld within broader social, political movements, cultural and political ideologies and religions.

SRHR cannot be achieved within a narrow, traditional understanding of health systems. It is important to consider the dynamic and context-specific approach that respects individual, couple, family and socio-political beliefs without violating individual rights. Achieving UHC and ensuring that all people including vulnerable populations receive quality, rights-based, non-discriminatory SRHR services without financial hardship is underpinned by strengthening the health system and the broader political, economic, social, cultural and gender context.



PART B:

Core strategic actions to achieve universal access to comprehensive sexual and reproductive health services



SECTION 1: Planning and implementation in order to achieve universal access to sexual and reproductive health services: health systems, gender equality and human rights considerations

Key considerations for implementation



Inclusion of sexual and reproductive health services in national health policies, strategies and plans



Capacity building of the health system to support implementation of an increased package of sexual and reproductive health services



Commitment by leadership and partnerships with key stakeholders



Review and revision of national sexual and reproductive health policies, strategies and plans



Creation of supportive legislative and regulatory framework



Determining implications of key finance and budget for implementing SRH services



Implementation of sexual and reproductive health policies, strategies and plans towards universal health coverage



Monitoring and evaluation of implementation of sexual and reproductive health policies, strategies and plans

IMPLEMENTATION CHECKLIST

Effective planning and implementation in order to achieve universal access to SRH care and services depends on a well-functioning health system. This includes the establishment of strong governance processes and partnerships and especially the involvement of civil society including women's groups, and vulnerable and marginalized groups, enabling policies and legislation, multisectoral engagement, and coordinated action across the other building blocks such as integrated health service delivery.

While the prioritization of actions to strengthen health systems for UHC will vary depending on country contexts and needs, it must be underpinned by a commitment to a human rights-based approach and on the principle of non-discrimination (9). This commitment to a rights-based approach is especially pertinent for the implementation of SRHR, where unmet needs for SRHR may persist even in well-functioning health systems (8).

In all contexts where UHC is a national commitment, planning, implementation and monitoring of SRH services, either within a national health strategy or health benefits package, stakeholders should be guided by the following principles (1,3,15):

- government stewardship and accountability, with monitoring and evaluation (M&E);
- strong coalitions with civil society organizations and communities; and
- protection and promotion of gender equality and human rights with the view to achieve equity, that is, leaving no one behind.

This requires a focus on the planning, implementation and monitoring phases, and taking into account the challenges unique to SRH that are located in the specific legal, policy, socio-cultural, equity and gender contexts of individual countries.



Inclusion of sexual and reproductive health services in national health policies, strategies and plans

Assess and strengthen the capacity of the health system to support implementation of an enlarged package of sexual and reproductive health services

High-performing and resilient health systems built on strong PHC are essential for UHC and achieving access to universal SRH. This also requires consideration of the availability or physical presence of services, and the readiness, capacity to deliver¹, of health systems and their essential building blocks. Availability and readiness have to be considered and aligned with the needs of the target population to support the implementation and delivery of SRH services (See Annex 2 for critical questions that have

to be addressed in assessing a health systems' capacity across the building blocks and examples of corresponding policy actions).

Planning and preparedness require a systemic approach and often multiple policy interventions (9) either within a single policy area (see case study 1 where implementation of safe-abortion services in Ireland necessitated several policy actions in service delivery) or across several (see case study 2 where the planning for the implementation of UHC benefit package with SRH integration in Pakistan required policy action in governance, human resources and health information).

Case study 1: Key actions for strengthening service availability and readiness for safe abortion services in Ireland

In December 2018, abortion became legal in Ireland on an individual's request up to 12 weeks' gestation, and thereafter if the pregnancy poses a life or serious health risk to the pregnant individual, or the fetus has a condition making it unlikely to survive before or within 28 days of birth. With abortion services slated to commence on 1 January 2019, the Irish Health Service Executive (HSE), the agency responsible for the provision of health services, prioritized several actions to assist in the successful implementation of these services. In line with guidance from the World Health Organization Safe Abortion: Technical and Policy Guidance for Health Systems (17), which states that abortion services should be readily available at the primary care level, General Practitioners are the main point of contact for those seeking antenatal services at less than 10 weeks of gestation in Ireland. To assist individuals seeking abortion services to

find a provider, the HSE established a website and hotline called MyOptions. The Irish College of General Practitioners, the professional and training body for Irish General Practitioners, issued clinical guidelines and online courses to ensure service delivery readiness for programme implementation through community service provision. Several workshops were conducted across the country to allow individuals to explore personal values and professional responsibilities related to provision of quality abortion care. The HSE published additional information on their website related to medical and surgical management of abortion, and what to expect after an abortion, with additional guidance for abortions in later gestations. The HSE also hired a clinical lead to support successful implementation of abortion services nationally and to address functional aspects of the health system.

Source: Favier and Lavelanet (2022).

¹ An assessment of service availability (for example, availability of key human and infrastructure resources, availability of basic equipment, essential medicines and diagnostic capacities and basic amenities) and service readiness of the health facilities to provide basic health care interventions (including contraceptive and family planning, child health, basic and comprehensive emergency obstetric care) is a critical element for effective services delivery (16).

Case study 2: Health systems assessment and planning for the implementation of a universal health coverage benefit package with sexual and reproductive health service integration in Islamabad Capital Territory, Pakistan

A finalized UHC-benefit package with integrated essential SRH services at community and primary care level is being piloted by the Ministry of National Health Services Regulation and Coordination in Islamabad Capital Territory before scaling-up to other provinces. Preparation and planning of the benefit package include assessing and strengthening the health system to support the package's implementation.

Governance and leadership

In 2019, a strategic policy dialogue involving national stakeholders on integrated reproductive, maternal, neonatal, child and adolescent health and nutrition recommended a review of and reforms in SRHR related laws in the country. The laws included in the dialogue related to abortion, pre-marriage counselling, early child marriage and SRHR education curriculum. A legal review of these laws was conducted to identify gaps in view of the global commitments and WHO guidance. A draft bill on mandatory maternal and perinatal death notification is prepared and in under review at the Health and Law ministries. Policy briefs will be used to support informed advocacy with parliamentarians and policy makers to ensure the required legal reforms are undertaken.

Health workforce

Updating of both in-service and pre-service training packages for facility and community-

based workers is ongoing. A consultative and participatory process was undertaken to develop standardized training packages on family planning separately for facility-based and community-based workers. Master trainers have been trained. The process for revision and updating pre-service training packages for facility-based staff began in early 2020 and will be completed by mid 2022 and that for community-based workers is also close to finalization stage. All revisions are in view of aligning the training packages to the UHC-benefit package for effective implementation.

Health Information System

A mapping of all public and private health facilities followed by a service availability and readiness assessment (SARA) of all health facilities was conducted using WHO's SARA tool in 12 priority districts for UHC implementation. A detailed abortion module was developed and added to the SARA tool that has been successfully piloted in Islamabad and replicated in the remaining 11 districts. The SARA findings are being used for planning implementation of the UHC-benefit package with integrated SRH services. In addition, digitization of all health records at community and primary care levels is also being piloted in Islamabad Capital Territory for real-time reporting and enhanced efficiency.

Source: Aabroo, Zaidi, Thom, Hemachandra and Uzma (2022).

Ensuring committed leadership and partnerships with key stakeholders

Effective planning and implementation to achieve universal access to SRH requires commitment from national level decision-makers and all relevant stakeholders in the health sector. Partnerships

between national decision-makers and national and international stakeholders² including social participation need to be built, expanded and strengthened to mobilize and promote political will for the development of supportive policy and legislation, planning, implementation and monitoring and evaluation (18). National decision-

² These stakeholders (within and beyond the health sector) include the public, target populations, national civil society (for example, organizations representing the interests of women, youth, minorities) and international civil society and non-governmental organizations, private sector (profit and non-profit) providers, professional associations, parliamentarians, international and multilateral organizations, bilateral agencies, humanitarian relief agencies (in conflict and crisis settings) and academic and research institutions.



makers, especially those in SRH, must ensure that stakeholders are engaged throughout the processes and to ensure accountability through for example:

- fostering citizens' platforms and people's voice mechanisms;
- developing policy dialogue platforms and multisectoral action;
- promoting regional and global mechanisms for collective action and partnership; and
- setting up a national coordination and oversight mechanism comprising key stakeholders within and outside of health, tasked with monitoring and evaluating the implementation of the plan.

Review and revise national sexual and reproductive health policies, strategies and plans

Under the leadership of ministries of health, existing SRH policies, strategies and plans should be reviewed and updated, if necessary, to be in line with global and regional commitments towards SRH, PHC and UHC. This process should be informed by a situation analysis of existing SRH programmes and services, with particular attention to defining the needs (access, quality of care and financial protection) of women, marginalized and vulnerable populations. The plans and strategies should include a monitoring framework with clear and actionable process, output, outcome and impact indicators to assess the progress of implementation against the formulated goals (see section 4 on monitoring and evaluation).

Ensure supportive legislative and regulatory framework

Existing laws and regulations that affect provision and access to SRH services should be reviewed and brought into alignment with human rights laws and standards (19,20). Examples of laws and regulations that affect provision and access to SRH services include age of consent laws, non-availability of abortion services on request, and laws that do not define rape within marriage as a crime or that require mandatory reporting of partner violence. In addition, laws that criminalize certain populations who have particularly acute SRH needs, such as sex workers, should be assessed in light of their impact on equitable access to SRH services. A situational analysis may reveal the need for legislation or other regulatory action to protect people seeking SRH care, such as stronger professional standards regarding consent, confidentiality, demands for informal payments or verbal abuse of patients.

Determine the key financing and budgetary implications for implementing SRH services

The effective and sustainable implementation of SRH interventions requires financing and budgetary considerations. This is especially important for lower-middle-income countries where there is increasing focus on ensuring domestic funding for sustainability. At the same time, especially for low-income countries, reliance on donor support will most likely continue and the international community, including philanthropic organizations, will continue providing funding for SRH interventions with a focus on reaching those most in need and removing financial barriers to accessing health services (21).

To ensure progress towards UHC, it is critical that SRH interventions (either within a national SRH strategy or health benefit package) are costed (determining what resources are required to deliver the services covered) and compared against the existing fiscal space, that is, compared to what resources are available to deliver the services covered (22,23). While ensuring an alignment between funds required and those available to deliver health benefit packages and national health strategies is essential, it is equally important to ensure that the health system has the capacity to deliver the promises made, which requires a consideration of the health budget. From a gender equality perspective, it is important that gender-responsive budgets are considered in health financing. In settings which adopt gender budgeting, this may result in policies that draw attention to the SRH needs of women and steer resource allocation decisions accordingly.

Box 4: Key definitions

The **fiscal space** for health refers to public funding available for health which sets limits for the size of the health benefit package and implementation of publicly funded health services (23).

A **health budget** is the portion of the national budget allocated to the health sector, including all ministries and agencies involved in health-related activities (23).

A **gender responsive budget** refers to integrating a clear gender perspective within the overall context of the budgetary process, through the use of special processes and analytical tools, with a view to promoting gender-responsive policies (24).

Implementation of sexual and reproductive health policies, strategies and plans in order to achieve universal health coverage

Implementation of SRH policies, strategies and plans, focusing on expanding service coverage, quality of care, population coverage and improved financial protection requires a phased approach. This requires prioritizing implementation of SRH services at population and primary care level and taking incremental steps with expansion (for instance, with service delivery platforms) and scale-up (for example, additional facilities and population groups) as additional resources and implementing institutions and capacities are strengthened. This ensures progressive realization towards UHC and increase access to essential SRH services.

The prerequisites for successful implementation of SRH policies include:

- ✓ **Taking action on legal and policy barriers through multisectoral coalitions:** ensuring that legal and policy barriers that constrain accessibility, availability, acceptability and quality of SRH services are addressed through multisectoral coalitions and coordination and ensuring that an effective referral system between health and other sectors is available;
- ✓ **Taking action on addressing demand side barriers that affect access to treatment:** these barriers to be addressed include social, cultural and gender factors including stigma and discrimination, as well as the added considerations of respect for patient culture, autonomy and choice, and dignity in service delivery;
- ✓ **Knowledge of rights, entitlements and responsibilities among the target population:** the target population must be well informed of their rights, entitlements to services and responsibilities³;
- ✓ **Sufficient resources are available for implementation and are allocated:** the required financial and human resources, infrastructure, medicines and technologies, updated clinical protocols and other resources are available as required to ensure the adoption and translation of evidence-based interventions into effective service delivery;
- ✓ **Informed, supported and enabled health care providers:** it is essential that health care providers are well informed of their roles, responsibilities, rights and plans and are enabled to carry out their work through ensuring that the work environment is supportive with opportunities for professional growth paying special attention to frontline providers;
- ✓ **Adaptive and responsive health systems:** the capacity of health systems must be strengthened to recognize and respond to emerging challenges, adapt policy and programme implementation and maintain essential SRH services based on emerging data and evidence (25); and
- ✓ **Robust monitoring:** an oversight body is required that is responsible for monitoring implementation of national action plans.

³ This information may be conveyed through, for example, mass communication campaigns and partnering with civil society organizations to improve health literacy and create demand for appropriate services.



Monitoring and evaluation of the implementation of sexual and reproductive health policies, strategies and plans

Robust monitoring and evaluation of the development and implementation of national SRH policies and strategies at national and subnational level are important for ensuring that the policies are implemented as planned and expected, thereby minimizing the implementation gap and building accountability and transparency in feedback and reporting to all relevant stakeholders. This requires the selection of appropriate process, output and outcome indicators (see Annex 3 for examples). While these indicators are specific to the health system (26), it is also important to track progress on gender, rights and equity policies that impact SRHR (such as non-discrimination acts and regulations,

equal access to education and information, laws on domestic violence, legal minimum age at marriage and gender responsive budgeting mandated in the constitution).

Monitoring and evaluation must be complemented by context-specific research that assesses the implementation processes, specifically the barriers to achieving the stated goals and targets that exist at all levels of the health system, and the implementation gap (see case study 3 for the catalytical role that evidence played in driving policy action towards improving quality of facility-based deliveries in Guinea).

Case study 3: Catalysing policy action through evidence of the mistreatment of women during facility-based deliveries in Guinea

The right to respectful and non-discriminatory care is an important dimension of quality care (27). While relevant to all areas of health, there has been increasing documentation of the violation of rights in the mistreatment of women during childbirth, abortion, fertility treatments and contraception (28), as well as has been demonstrated in the detention of women in health facilities for non-payment of fees (29). The documentation of the lived experiences of women can be a powerful catalyst for change as demonstrated in the case of Guinea.

Prompted by a 2019 publication in *The Lancet* (30) of a WHO led study on mistreatment of women during facility-based childbirth in four countries (Ghana, Guinea, Myanmar and Nigeria), the Centre for Research in Reproductive Health in Guinea (CERREGUI) convened a meeting comprising ministry officials with maternity hospital directors, nongovernmental organizations, professional associations and international agencies to

present the research findings (30). Together they developed a set of recommendations which could be implemented at the national level to reduce the mistreatment of women during childbirth.

These recommendations included practical steps such as allowing chosen birth companions and accepting the birth position desired by the woman, as well as health system changes such as scaling up training in respectful maternity care and strengthening governance and oversight. After being accepted by the Ministry of Health, these recommendations have been incorporated into the Reproductive, Maternal, Newborn, Infant, Adolescent Health and Nutrition (SRMNIA-N 2020-2024) Strategic Plan and the Muskoka Action Plan of 2021. Some health facilities are already taking steps which have made a significant difference to the well-being of women. For example, birth companions of choice are being accommodated in the National Teaching Hospital, Ignace Deen.

Source: Mehrtash and Tuncalp (2022).

Checklist for the planning and for the implementation of national sexual and reproductive health policies and strategies

This checklist draws from lessons learned from the *Joint Assessment of National Health Strategies and Plans (31)*. It allows a comparison of current SRH national health policies and strategies with the practices outlined below to assess and identify gaps and areas that require strengthening. This requires assessing the following:

BACKGROUND
A

POLICY ACTIONS
B

IMPLEMENTATION
1

INCLUSION
2

ACTIONS
C

SERVICE DELIVERY
3

ACCOUNTABILITY
4

1



Is the formulation of the policy or strategy, its implementation, monitoring and evaluation based on a comprehensive consultative process with a diverse range of stakeholders?

2



Does the policy or strategy pay close attention to the participation of stakeholders who in some settings are hard to reach such as representatives of women's groups, youth groups, key populations, ethnic minorities and people with disabilities, and does it include programmes for ensuring their participation?

6



Does the policy or strategy include an assessment of the health system's needs and readiness, and does it provide policy actions to implement and meet the needs of the population? This, for example, includes ensuring that clinical guidelines and service standards are in place to ensure the effectiveness, safety and quality of SRH services, that essential SRH medicines on the WHO Model List of Essential Medicines are included in national essential medicine lists, and appropriate provider payment mechanisms are in place to ensure access to and quality and efficiency of SRH services.

7



Does the policy or strategy provide for adequate review, monitoring and accountability including a monitoring and evaluation framework to measure progress in addressing inequities in financial access, service delivery and access to quality SRH services?

3



Does the SRH policy or strategy, either in its formulation or revision, identify existing laws and regulations that affect provision and access to SRH services that need to be reviewed and brought into alignment with human rights laws and standards and does it explicitly include and promote principles of gender, rights, equity, as well as transparency and accountability?

4



Have key financing and budgetary implications for implementing SRH services been considered including gender responsive budgeting and other related principles?

5



Have mechanisms for improving financial protection and access to SRH services through appropriate prepayment mechanisms (including sustainable domestic and international financing) been identified for implementation?

8



Does the policy or strategy identify appropriate institutions or bodies to monitor and address issues relating to quality, access, financial protection and non-discriminatory care?

SECTION 2: Inclusion of comprehensive sexual and reproductive health services in health benefit packages as progress towards universal health coverages

Key considerations for inclusion



Key policy actions for ensuring that sexual and reproductive health services are comprehensively integrated within health benefit packages



Transparent and inclusive engagement of all relevant sexual and reproductive health stakeholders in the health benefit packages decision-making process



Evidence-based priority setting process



Advocating inclusive priority setting criteria with equity, rights and gender equality



Use of evidence for advocacy towards prioritization of sexual and reproductive health services in health benefit packages



Strategic reframing a contested sexual and reproductive health service

INCLUSION
CHECKLIST



As countries make changes to the entitlements defined in their health benefit packages in order to make progress towards UHC, this will entail decisions about what services will be included as an essential health service and made available to all citizens from public funds (32). The evidence indicates that apart from maternal health (antenatal care, intrapartum care and post-natal care) and to a slightly lesser extent family planning, other critical SRH services (such as safe abortion and post-abortion care, prevention and treatment of gender-based violence and fertility care) are often excluded from health benefit packages (33–35).

This section provides guidance on and issues for consideration as part of comprehensive SRH services in health benefit packages aimed at attaining UHC.

WHO has identified the three common steps of data, dialogue and decision collectively known as 3D in the priority setting process (32). In the data stage,

scientific evidence (for example, both quantitative and qualitative data on topics including burden of disease, cost-effectiveness, budget impact, resource needs fairness, equity and acceptability) is generated to support decision-making. The dialogue step involves a deliberative process to appraise the data, and the decision step is where recommendations are made to support decisions. There are several analytical tools available for the 3D process. For example, at country level, WHO's [UHC Compendium of Health Interventions](#) is an important resource for supporting the design of health benefit packages, service planning and supporting the data aspect of the 3D framework.

This section focuses attention on the dialogue process and decision steps. For these steps, representation and inclusion of relevant stakeholders is a critical component to inform the entire decision-making process from the data phase up to making a decision, particularly for decision-making regarding service prioritization and funding allocations.

Box 5: Definitions related to health benefit packages and design

Health Benefits Package: This is a set of services that can be feasibly financed and provided under the actual circumstances in which a given country finds itself (36).

Essential Package of Health Services: a policy statement of intent and commitment that may or may not be supported by adequate financing (33).

Benefit Design refers to decisions about those health services and goods to be funded, either fully or partially, from public revenues as well as decisions about which services to exclude.

Key policy actions for ensuring that sexual and reproductive health services are comprehensively integrated within health benefit packages

Review global guidance on integrating SRH services within national UHC strategies and plans

It is recommended that WHO's [UHC Compendium of Health Interventions](#) and the [Comprehensive SRH services in UHC](#) are important resources to support the deliberative processes for countries developing a new or adjusting an existing health benefit package.

This guidance should be considered alongside a review of the extent of inclusion of comprehensive SRH services within health benefit packages. In instances when services are excluded, the reasons should be identified (see Annex 1) since this will help to determine the appropriate action and steps towards future inclusion in a health benefit package.

Ensure transparency and inclusive engagement of all relevant sexual and reproductive health stakeholders in the health benefit package decision-making process

Three key elements of good governance that improve the health benefit package decision-making process are transparency, consistent, stable and coherent decision-making structures and participation (37). Effective and trustworthy priority setting processes require engagement with, and collaboration among, stakeholders⁴ within a transparent, rules-based process (38).

In practice, the stakeholders that will be eventually engaged are context specific and will differ across settings. However, irrespective of the setting, the starting point for ensuring that SRH is

comprehensively integrated within a health benefit package is to ensure that:

- 1 priority setting processes are transparent and participatory;
- 2 efforts need to be made to include those who are critical SRH stakeholders, as well as those who are hard to reach but likely to be left out such as representatives of women's groups, youth groups, ethnic minorities, people with disabilities; and
- 3 recognition that while different stakeholder groups may have differential power and interests, voice and influence, it is important to balance these differences and ensure participation of all stakeholders in the decision-making processes on equal terms.

Ensure that the priority setting process is evidence-based

Revisions to health benefit packages should be undertaken with emerging new evidence, epidemiological changes, needs of the population and budgetary changes. The importance of reliable locally generated data cannot be understated where global data are not transferable (for instance, regarding costs). Increasingly, these data and dialogue approaches are being institutionalized through a health technology assessment (HTA) mechanism. As illustrated in the case for the inclusion of the human papillomavirus (HPV) vaccine in Thailand, it is critical to build evidence based on locally generated data (see case study 4).

⁴ Relevant stakeholders include civil society organizations, women's groups, health service users, academia and researchers, health care providers (public, private and NGOs) and professional associations, private sector, including industry and manufacturers, private hospitals and clinics, private health insurance, policy-makers and health planners, such as ministry of health or other ministries and funding partners (multilaterals, bilateral, donors).



Case study 4: Application of health technology assessment for the inclusion of the HPV vaccine in the health benefit package in Thailand

The National Health Security Office (NHSO) has been the managing organization for the Universal Coverage Scheme (UCS) covering 75% of Thai population since 2002. Its benefit package covers a whole range of health promotion and prevention, curative and rehabilitative services throughout the life course using a negative list approach, that is, a list of high-cost or cosmetic services is not included, though later a positive list approach was introduced such as universal ART, universal RRT, influenza vaccination, rare diseases and Preexposure Prophylaxis of HIV. Inclusion of positive lists into UCS benefit package are subject to rigorous health technology assessment. The benchmark for a cost-effective intervention is the incremental cost-effective ratio of one GNI per capita per one Quality Adjusted Life Year gain.

The process comprises of:

- i) the nomination of health intervention by representatives from several groups of stakeholders;
- ii) prioritization of the proposed health interventions by representatives from four groups (health professional, academics, patients and civic groups);
- iii) conducting technology assessments by research institutes;
- iv) appraisal of the recommendations by the Sub-committees on Benefit Package and Financing; and
- v) decision-making by the NHSO Board.

The participatory process enhances the inclusiveness, transparency and use of scientific evidence to inform policy-making processes in the context of fiscal space.

The HPV vaccine was proposed for inclusion in the benefit package in 2008. The Health Intervention and Technology Assessment Program (HITAP) recommended that a price of below US\$ 60 per dose was required for HPV vaccine to be considered cost-effective, and the price must be further reduced to maintain its cost-effective status, if Thailand could expand cervical cancer screening programme coverage from 30% to 75% of eligible women. As the market price was higher than this cost-effective threshold, the HPV vaccine was suspended from inclusion in the UCS benefit package. However, this study provided a threshold price for NHSO to negotiate with vaccine manufacturers.

In 2017, after intensive price negotiations with the vaccine industry, the price per dose of HPV vaccine reached the cost-effectiveness threshold. This allowed the government to include the HPV Vaccine into its Expanded Programme on Immunization and launched the two-dose regimen of the school-based HPV vaccination programme for all grade five schoolgirls.

Source: Panichkriangkrai and Tangcharoensathien (2022).

Advocate for priority setting criteria to include equity, rights and gender equality

It is acknowledged that concerns over affordability and efficiency may override those of equity,

especially in resource-constrained settings. As illustrated in box 6, prioritization of SRH services requires advocacy for priority-setting criteria that include equity, gender equality and social values, grounded in the principle of human rights.

Box 6: The burden of disease from a gender and equity perspective: obstetric fistulas

Obstetric fistulas remain a significant maternal health issue, especially in resource-poor regions where maternal mortality rates are high and access to emergency obstetric care is limited. Most women living with the disorder experience urinary or faecal incontinence due to fluid leaking into the vaginal canal through a hole resulting from complications in delivery. Living with obstetric fistulas leads to physical consequences (such as discomfort, having to wear protective cloths to absorb leaking fluid and having to apply scented perfumes to mask the smell) and stigma (being made to feel shame over the ensuing smells, being physically isolated from families and communities and facing divorce or abandonment).

Prioritizing the inclusion of the prevention and treatment of obstetric fistula in a national health benefit package to minimize the damaging long-term effects of such a condition may be based on criteria of the burden of disease (from the perspective of a specific population group), effectiveness (vaginal repair surgery is relative, simple and effective) and fairness (women who constitute half the population are suffering and being marginalized due to this health problem).

Source: (38)



Use evidence for advocacy towards prioritization of sexual and reproductive health services in health benefit packages

Requests for SRH assessments and subsequent policy dialogues are opportunities for using evidence

to advocate for prioritization of SRH services and their inclusion within health benefit packages. This is illustrated in the use of sexual, reproductive, maternal, newborn, child and adolescent health (SRMNCAH) assessments by six European countries (case study 5).

Case study 5: Policy dialogues in six European countries initiating sexual and reproductive health plans

Assessments of SRMNCAH in the context of UHC were undertaken in six countries (Albania, Azerbaijan, Kazakhstan, Kyrgyzstan, Romania and the Republic of Moldova) in the WHO European Region. Among others, a review of health benefit packages in relation to SRH was done to understand financial risk protection for SRH services.

In brief, the findings were that:

- The official state health benefit packages are often underfunded. Despite officially being all-inclusive, covering a wide range of SRMNCAH and other services, the general lack of resources leads to rationing of services and out-of-pocket payments;
- There are limited explicit mechanisms to set priorities, pushing rationing decisions to the provider level using both formal and informal mechanisms. None of the countries have clear, defined criteria or processes for deciding which SRH and other services should be included in their health benefit packages or subsidized, and none have the strategic purchasing capacity to drive quality improvements; and
- Contraceptives are generally not covered by health benefit packages, but in some countries included in vertical programs causing fragmentation in health system and HPV vaccination is not included in routine immunization programmes. While testing

for STIs is officially free, treatment is often paid fully or partially by patients themselves. Abortion, except in the case of miscarriage or for medical reasons, is not covered in any of the countries.

These findings sparked a policy dialogue with a number of stakeholders in each country, including decision-makers at health insurance funds. The policy dialogue took place directly in connection with the assessments, during a multi-country meeting with all the assessed countries and through follow up with each country. As a result, the development of SRH action plans was initiated in Romania and Kyrgyzstan to include SRH interventions more fully in their health benefit packages. In Kazakhstan, amendments on reproductive health and rights were made to the new Code on Populations and Health Systems (39) and access to SRH services for teenagers under 16 years of age without parental consent were introduced. Overall, the assessments, using a strong health systems approach, presented an opportunity to build and strengthen the evidence base for UHC and SRH to more effectively advocate for policy change for SRHR.

Integration of SRHR into the UHC agenda is a continuous process. Countries in the WHO European region are encouraged to carry out similar reviews with an aim to track SRHR in advancing UHC and as an instrument for policy dialogue around it.

Source: Berdzuli and Ostergren (2022).

Strategically reframe a contested sexual and reproductive health service

Strategic reframing of an SRH service that is considered to be socially or politically sensitive and excluded from a health benefit package can potentially advance its inclusion. In the following example from Malaysia,

in the wake of global landmark events relating to human rights, including women's reproductive rights, and national reform to laws and policies, a window of opportunity opened for civil society working on gender-based violence (GBV) to advocate for considering it as a health issue and integrating its services into tertiary trauma care. (Case study 6)

Case study 6: Priority setting in integrating services for the prevention and treatment of gender-based violence in Malaysia

Malaysia has a welfare-oriented health system, which emphasizes the provision of free (or almost free) public health care services, subsidized by the government. This was a key focus area in the early 1960s in the newly independent country driven by a need to cater to the predominantly rural population and to respond to voters. The prioritization of health care was usually formulated by involving all stakeholders in the health sectors, based on an in-depth understanding of both the health care needs and challenges, available government funding and essential services which were deemed good value for money.

In Malaysia, GBV was perceived as a private matter and taboo. Entrenched social and cultural norms meant that GBV was seldom discussed and thus, not addressed until 1994 with the establishment (and roll out in 1996) of the One Stop Crisis Centre (OSCC).

A combination of factors was responsible for GBV becoming a priority area in Malaysia. First, there was a burgeoning international movement and commitment to the rights of women and sexual and reproductive health, notably ICPD, the Beijing Declaration and Committee on the Elimination of Discrimination against Women, which gradually influenced views within the country. Second, a robust network of

women-led NGOs existed, with vast grassroots experience and people who could advocate for those affected by domestic violence, as well as prominent individual political champions. The culmination of these persistent efforts led to legal reform, whereby the Domestic Violence Act was passed under the Penal Law in 1994 and provided a window of opportunity for the women-led NGOs to work with health experts. These advocates and NGOs reframed GBV as a matter concerning public health, which facilitated buy-in from many stakeholders. Shortly after, a pilot of the OSCC model was implemented at the Hospital Kuala Lumpur, spearheaded by the Director of the Accident and Emergency department through close working relationships with key stakeholders, including the police, social welfare, legal aid and NGOs.

The OSCC represented a feasible and successful model to respond to GBV through a multi-disciplinary, multisectoral and integrated approach using existing resources within the hospital at no additional cost to the Malaysian Ministry of Health, which eventually gained their high-level support. Subsequently, the Ministry directed all state hospitals to integrate OSCCs within accident and emergency departments, within their existing budget envelopes and produced official guidelines in 2015.

Source: Remme, Lim and Barmania (2022).



Checklist for ensuring inclusion of the implementation of comprehensive sexual and reproductive health services in health benefit packages

The following considerations and questions are essential for ensuring the integration of comprehensive SRH services in health benefit packages as part of national priority-setting processes towards UHC:

BACKGROUND
A

POLICY ACTIONS
B

IMPLEMENTATION
1

INCLUSION
2

ACTIONS
C

SERVICE DELIVERY
3

ACCOUNTABILITY
4

1



Are comprehensive SRH services prioritized within PHC in the development of the health benefit package?

2



Which SRH services are included, and which are excluded?

7



Is there publicly available information about what SRH services are included in the health benefit packages to which people are entitled? Does it include information about how the services are financed?

6



Do the priority-setting criteria include equity, rights and gender equality alongside impact, affordability and efficiency?

8



What level of financial protection is there for each SRH service, especially those for women and girls, as well as marginalized and vulnerable groups?

3



What were the reasons for the exclusion of specific SRH services (see Annex 1 for potential reasons)?

4



In the case of excluded services, what are the potential actions, for instance, appeal mechanisms or policy actions, for challenging exclusion and progressing towards inclusion?

5



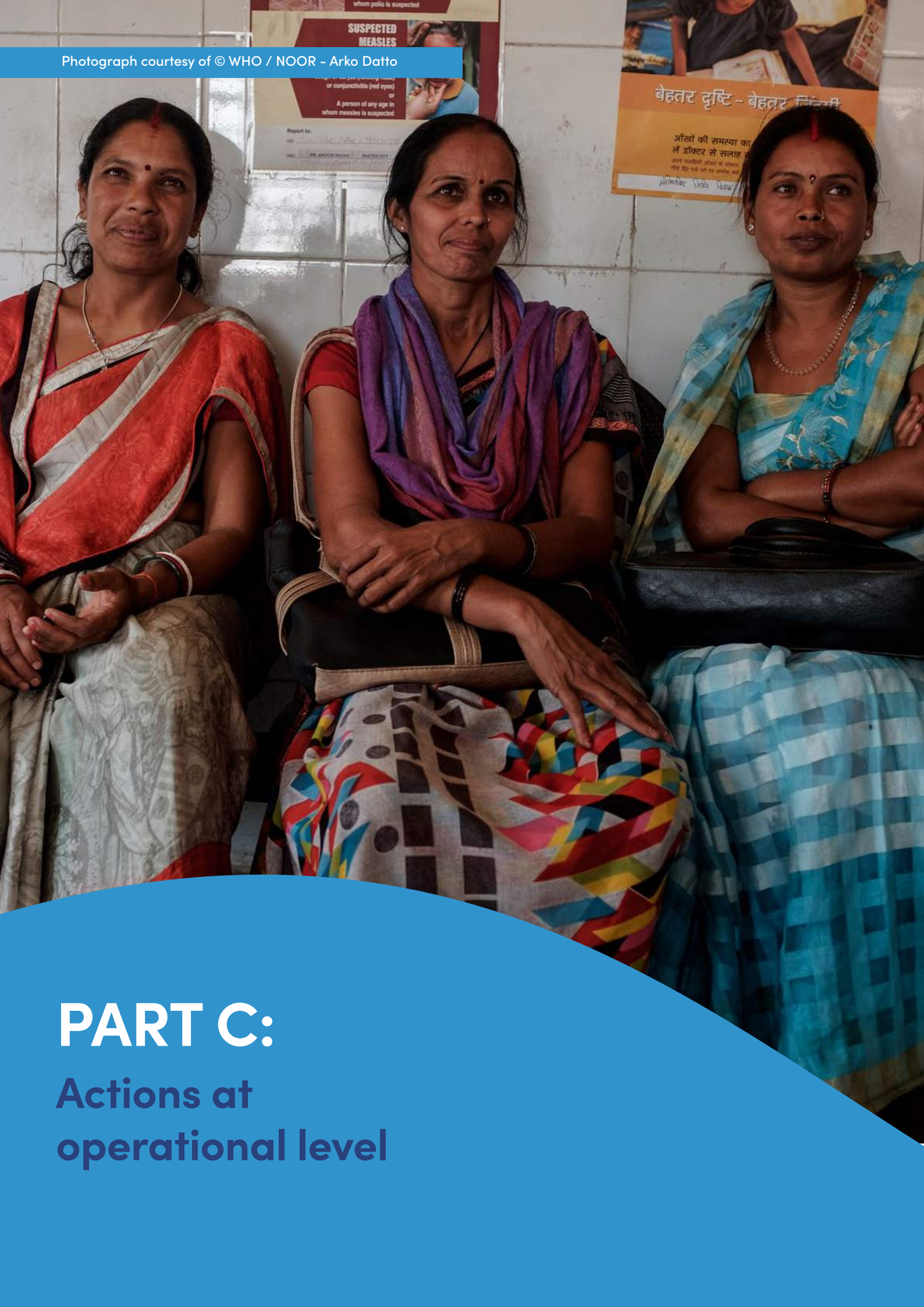
Were stakeholders, who in some settings are hard to reach (such as representatives of women's groups, youth groups, key populations, ethnic minorities and people with disabilities) included in the priority setting processes and what were their roles?

9



Is there a monitoring system to ensure that services in the health benefits package that are mandated to be free to users, are in fact free including at PHC level?

Photograph courtesy of © WHO / NOOR - Arko Datto



PART C:

Actions at
operational level



SECTION 3: Integration of sexual and reproductive health services delivery in universal health coverage through a primary health care approach

Key considerations for service delivery



Health system considerations for integrated sexual and reproductive health service delivery



Undertake a situational analysis to identify opportunities to improve access to services and inefficiencies in health service delivery



Clarify the objectives of services to be integrated with key stakeholders



Improve coordination, joint planning and decision-making among all stakeholders and at all levels of service delivery



Strengthen linkages, effective referral systems and collaboration within the health sector and other relevant actors and sectors



Strengthen the availability and competencies of the health workforce to expand access to critical SRH services and optimize primary care delivery



Systematically monitor and evaluate service delivery

Over past decades, “vertical” and “stand-alone” structures for specific SRH services have contributed to important gains in health access and outcomes especially when targeting the needs of marginalized and vulnerable groups (40). However, in many settings, fragmentation, poor patient experience, unsafe delivery and missed opportunities to deliver essential services are driving the quest for improved effectiveness in terms of access, comprehensiveness, coordination and continuity of care. While resource constraints are driving the need for improved health system effectiveness, equity and efficiency, requiring shifting from vertical programmes towards health service integration (40,41). This section provides guidance on and considerations for delivering SRH services within the broader context of integrated health services, emphasizing primary care and essential public health functions.⁵

There are several motivating factors driving integrated SRH. First, attending two or more separate services to meet multiple health and social

care needs (such as counselling and psychological support) increases costs and takes up a patient’s time, while receiving integrated care for several health needs at the same time can reduce the patient-burden by reducing consultation times and therefore overall waiting times. Second, in low-income settings where skilled human resources are often lacking, integrated service delivery has the potential to improve service effectiveness and efficiency and optimize the use of limited resources and clinical staff time. Integrated health services can be achieved through co-location of services (one-stop-shop) or cross-referrals (42).

Integrated service delivery does not imply incorporating every service into one package, or necessarily delivering services in one place. It is about arranging services so that they are not disjointed and are easy for the user to navigate. Joint working relationships within and between agencies in the health and social care sectors can optimise resources and facilitate overall efficiency (43).

Box 7: Definition of integrated health services

Integrated services are those that are managed and delivered so that “people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease-management, rehabilitation and palliative care services coordinated across the different levels and sites of care within and beyond the health sector, and according to their needs throughout the life course” (42). Further integrated service delivery is essential for reducing fragmentation, improving efficiency and meeting people’s needs for accessible, acceptable and convenient people-centred health systems. Ideally integrated services are built on a foundation of strong primary care and essential public health functions.

Box 8: Definitions of one-stop-shop and cross-referral models

One-stop-shop (co-location): provision of two services or more to a population group on one site (based on multi-disciplinary teams including the primary care team) to expand the capacity of health systems to deliver comprehensive services within primary care and integrating primary care with social care and other sectors (42).

Cross-referrals: delivery of two services or more with the same target population in different health facilities through referrals. Vertical cross-referrals refer to the incorporation of services across different levels of care (such as district hospitals, health centres and health posts) (42).

5 The European Framework for Action on Integrated Health Services Delivery identifies the following elements for effective service delivery processes: designing care, organizing providers and settings, managing services delivery and improving performance (42). Integration is a key enabler to effective health service delivery which explains the focus of the section.

Health system considerations for integrated sexual and reproductive health service delivery⁶

Effective integration of SRH services depends substantially on the health system in which it is embedded, involving much more than the content of policies and type of services (40). A functioning linkage between structure, policies and resources (collaboration, teamwork, incorporated policy decision-making and management) is an important component of SRH service delivery (42). In making decisions regarding which services to provide at any given level, policy-makers will need to consider the capacities of available health care providers, regulatory mechanisms for prescribing and scope of practice, the available equipment and supplies and whether referral to other sites or levels of the health care system is feasible or desirable, and the needs and preferences of the target population. They will also need to take into account local social and cultural norms in making decisions about what services are provided by the same providers, as opposed to those that are integrated through referral mechanisms. Models of care should promote integrated SRH services, strategically prioritizing primary care and public health functions and ensuring adequate coordination between them. These models of care must be tailored to local contexts (2).

The following conditions or steps are necessary for effective integrated SRH service delivery (44).

Undertake a situational analysis: The analysis must incorporate an assessment of current and projected demand for SRH services, public perception of SRH services, types of SRH services currently provided and service pathways, resource gaps and wider programme (for instance, between SRH

and HIV/AIDS) and sector linkages (such as education and social services). This is important for identifying opportunities to improve access to quality SRH services and reduce inefficiencies in service delivery through service delivery integration both within and between the public and private sector (for example, in contracting private providers for service delivery) and beyond the health care sector. The involvement of civil society organizations, community members and religious figures is important for mobilizing large-scale improvements in SRH, especially in primary care.

Clarify the objectives of services to be integrated: These objectives may be to improve one or more of the following: access for underserved populations at primary care level and specifically addressing gender and other equity barriers, quality of services, cost-saving, reducing duplication of services and efficiency, among others, through an appropriate integrated service delivery model (45–47).

Improve coordination, joint planning and decision-making: Effective integrated SRH service delivery requires participatory decision-making and coordination that is inclusive of the diverse range of stakeholders such as decision-makers, service delivery managers, health care providers, community of patients and civil society, and between different policies and programmes aimed at ensuring that necessary linkages are established at all levels of service delivery (42,43,48).

Box 9: Health system and integrated sexual and reproductive health service delivery

Integrated service delivery cannot be considered a solution to health systems that lack human and financial resources for SRHR. Providers cannot be expected to continuously add more duties upon those they already have. Integrated service delivery may provide some savings but cannot be sustained without the whole system being continually resourced. In a similar vein, building the capacity of health care providers to deliver multipurpose services does not discount the importance of specialization. Increasing the degree of specialization is an essential part of an appropriately structured delivery system.

Source: (42)

⁶ These considerations build on the operational levers of the PHC Operational Framework: models of care, primary health care workforce, physical infrastructure, medicines and other health products, engagement with private sector providers, purchasing and payment systems, digital technologies for health, systems for improving the quality of care, primary health care-oriented research and monitoring and evaluation (2).

**Strengthen linkages, effective referral systems and collaboration within and outside the health sector:**

Creating linkages and developing effective referral systems and networks among levels of care, such as centres to handle sexual violence, is essential. Strengthening referral systems requires improving infrastructure, implementing a standard referral system monitoring toolkit and curriculum to train health workers on referral policies and guidelines, developing standard referral forms or registers and providing adequate funds for implementation monitoring and evaluation (49).

**Strengthen the availability and competencies of the health workforce⁷:**

Adjust scopes of practice, if needed, to expand access to critical SRH services and to optimize primary care delivery. Given the centrality of the health workforce and specifically the need of additional competencies to deliver integrated care, strategies for addressing health workforce shortages (for example, integration of community health workers in multi-disciplinary teams (50–52) and ensuring effective team-building and managerial support (including supportive supervision, mentorship and opportunities for professional growth) are essential considerations (48). Actions to ensure that models of care adopt a PHC orientation are essential. The health workforce must also have the adequate competencies to deliver the specific SRH services within their defined role, these should be service specific, wherein these actions will be geared towards increasing health and care providers' skills, competencies, positive attitudes, respect and empathy (53).⁸

The alignment of health worker education and skills to community and population needs and strengthening education and training institutions to scale-up and sustain the production of PHC workers in appropriate quantity, quality, and relevance to respond to current and future health priorities is also essential. The challenges of effective human resource planning are illustrated in case study 7 (Postpartum and child immunization services integration in Burkina Faso: human resources opportunities and challenges) and 8 (Service delivery integration to support elimination of mother-to-child transmission [EMTCT] in Morocco: the challenges of health systems planning and co-ordination).



Monitoring and evaluation: Systematic monitoring of service delivery performance, including the performance of SRH services is needed to determine whether the desired results are being achieved, to identify obstacles to smooth implementation and to provide early warning of any adverse effects (54). Also related is the requirement for identification of appropriate process and output indicators to monitor service delivery performance as integration progresses.

7 It is essential that countries ensure that care providers maintain an adequate level of competence. The WHO document "Sexual and reproductive health core competencies in primary care" (53) presents the core sexual and reproductive health (SRH) competencies that are desirable for use in primary health care.

8 The World Health Organization is developing a "Global Competency Framework for UHC". The Organization is also developing a "Sexual and Reproductive Health and Rights Competency Framework for Primary Health Care Level: Family Planning and Comprehensive Abortion Care".



Case study 7: Postpartum and child immunization services integration in Burkina Faso: opportunities and challenges for human resources

Postpartum care (PPC) is an often-neglected component of reproductive health services in Burkina Faso as in many Sub Saharan African countries. To improve PPC, a package of community and facility interventions integrating PPC and child immunization was implemented in 12 primary health care centres in Burkina Faso from September 2013 to December 2015. The rationale behind this integration of services was that women were willing to follow the vaccination schedule for their infant while they were less likely to follow up on PPC. At the visit for immunization, the infant health book was checked to see whether the mother had received PPC and if not, she would be referred to the maternity (located in the same health centre) for PPC services. If the woman came for PPC, she was checked for family planning services and her infant for immunization.

The implementation of the interventions included workshops with health workers in each facility, training of health workers on PPC interventions, the distribution of PPC checklists followed by quarterly supervision covering the provision of activities. This integration effort has contributed to moderate gains, such as improvements in the detection and management of postpartum maternal haemorrhage, sepsis and newborn fever. However, its full implementation was impeded by structural barriers throughout the health system and primarily those relating to wider challenges of human resource capacity (shortages, high turnover, unequal distribution between facilities) and lack of coordination and collaboration between staff within the primary health care maternity and dispensary units.

Source: Belemsaga, Goujon, Duysburgh, Degomme, Temmerman and Kouanda (2022).

Case study 8: Service delivery integration to support elimination of mother-to-child transmission in Morocco: challenges in health systems planning and co-ordination

To minimize stigma, discrimination and economic barriers, the roadmap for the elimination of mother-to-child transmission of HIV was based on a gender- and rights-based approach with the involvement of civil society and communities, and cooperation and collaboration between the various partners. The integration process was initiated and led by the Ministry of Health in collaboration with civil society organizations, the Global Fund, UNAIDS and other partners through National Consensus Workshops.

To address the economic barriers for People Living With HIV/AIDS, STI/AIDS services are provided free of charge at the primary care level. One of the key strategic interventions of the roadmap is the scaling up of access to free public and private sector services, including those by nongovernmental organizations, for the prevention of mother-to-child transmission of HIV and congenital syphilis.

Because the delivery of maternal health services has been relatively successful in improving access, these services are used as an entry point to improve access to HIV/AIDS and STI programmes. HIV/AIDS and STI services, including counselling, rapid screening test and post-test counselling are provided in PHC facilities at the maternal and family planning units during antenatal care visits (one-stop-shop). Where appropriate, referrals for HIV/AIDS treatment and support services are made.

Despite improvements in access, there have been challenges at the central and facility level which have impacted planning, implementation and service delivery. At the central level, even if there is coordination between the services involved in the maternal health, HIV/AIDS and STI programmes, each programme or service is managed by a separate entity with different sources of funding. At facility level, the health care providers' workload has increased since they are required to provide several distinct services. In addition, health care providers have not received additional reorientation training towards people-centred care for women, leading to challenges in quality of care. The following steps are being taken to address the challenges in integration:

- ✓ the maternal health, STI and HIV/AIDS programmes are setting up a joint action plan towards EMTCT of HIV and syphilis based on the WHO EMTCT guidelines (2017), focusing on integrated antenatal care and HIV/AIDS services in all health centres;
- ✓ the health information systems are being integrated to reduce the workload on health professionals; and
- ✓ additional training on integrated (maternal health and HIV/AIDS) people-centred approaches is being delivered to improve quality of care.

Source: Yahyane, El omrani, Assarag and Bezad (2022).



Checklist for ensuring effective, accessible and equitable delivery of integrated sexual and reproductive health services

Considerations for integrating SRH services into the broader service delivery context may be guided by the following questions (2,46,47,55):



3



Is there joint planning between relevant departments or programmes?

4



Has the service delivery model been clearly identified?

6



What is the nature of collaboration between the relevant departments towards programme management and implementation (for instance in the coordination of activities, integrated supervision of activities and integrated budgeting)?

5



Has it been validated by a proof of concept or pilot experience in the country?

11



To what extent is continuous engagement of different stakeholders (including facility-based providers and community health extension workers, clients, and communities and women's organizations) in programme planning, implementation and oversight ensured?

12



Is there a jointly coordinated monitoring and evaluation platform in place tracking relevant indicators?

SECTION 4: Accountability processes and measures for ensuring universal access to comprehensive sexual and reproductive health services

Key considerations for accountability



Accountability in the context of sexual and reproductive health services and universal health coverage in national health policies, strategies and plans

Guiding principles



Participation emphasizes community engagement in the policy cycle and values citizen empowerment through deliberative processes



Transparency of information availability in the public and private sector



Equity measures are used to reduce all barriers to access for vulnerable groups that are often disadvantaged in terms of service coverage and health

Types of accountabilities



Political or democratic: ensure that the government responds to societal needs and concerns, delivers on electoral promises and fulfils the public trust



Performance: governments holding their own functionaries answerable internally for implementing SRHR sensitive UHC plans



Financial: tracking and reporting for ensuring universal coverage of SRH services for the most marginalized



Monitoring and evaluation framework for strengthening accountability in sexual and reproductive health service policy and implementation

ACCOUNTABILITY CHECKLIST

- BACKGROUND A
- POLICY ACTIONS B
- IMPLEMENTATION 1
- INCLUSION 2
- ACTIONS C
- SERVICE DELIVERY 3
- ACCOUNTABILITY 4



Accountability processes and measures are essential for ensuring progress on the commitments made towards ensuring universal access to SRH services (SDG 3.7), attaining UHC (SDG 3.8) and human rights. Strengthening accountability to support the formulation and implementation of robust and comprehensive national SRH policies and strategies is a necessity for improvements in sexual and reproductive health outcomes (54). More specifically, in the context of ensuring universal access to SRH services and UHC, accountability and its related processes and measures is critical for ensuring (57):

- inclusive and deliberative priority setting processes towards the development of health benefit packages that translate into access to quality and comprehensive SRH services;
- SRH services uptake by the population, especially by the most marginalized. These services must be responsive to the specific health needs of different groups;
- effective, quality and affordable delivery of SRH services through effective monitoring, review and action; and
- country ownership of SRH programs and services.

This section provides guidance on key elements for the design and implementation of accountability processes and measures to drive and monitor progress on the implementation of national SRH policies and strategies and commitments in UHC and PHC contexts.

Accountability in the context of sexual and reproductive health services and universal health coverage

Accountability is a relationship between a duty holder and a person or organization to whom a duty is owed (WHO, 2020; (18)). It may also be understood as the “the processes by which government actors are responsible and answerable for the provision of high-quality and non-discriminatory goods and services (including the regulation of private providers) and the enforcement of sanctions and remedies for failures to meet these obligations” (58). Participation, transparency, democracy, and equity are essential guiding principles for accountability processes and of specific relevance for SRH in the following ways (59).

Participation emphasizes community engagement in the policy cycle and values citizen empowerment through deliberative processes. Structures need to be in place to provide opportunities to different stakeholders to engage in decision-making, monitoring and evaluation processes or to participate in resolving issues related to finance, programme or governance processes. This can range from being “informed” to “influencing”, “agenda-setting” or “decision-making” on SRHR in UHC. Participation of stakeholders in setting agendas and decision-making is crucial to building accountability.

Transparency refers to the availability of the information in the public and private sector so that the actions and decisions of public and private servants are visible and understandable to the citizens at large. Legislation including citizens’ right to information, right to public participation, and the devolution of powers to local bodies are essential for transparency. Multilateral and stakeholder organizations can provide guidance on how robust government transparency can be realized. An important point to address is the lack of data and evidence on the need for, provision of, and efficacy of comprehensive SRH services (60).

Equity measures are used to reduce all barriers to access for low-income groups especially at primary care level, rural populations, women, people with disabilities and other vulnerable groups that are often disadvantaged in terms of service coverage and health.

The different types of accountabilities include political or democratic, performance or financial (59), and may be operationalized in the context of sexual and reproductive health and reproductive rights as follows (57):

- 1 Political or democratic:** institutions, procedures, and mechanisms that ensure that the government responds to societal needs and concerns, delivers on electoral promises and fulfils the public trust. Examples of these include: decision and policy-makers engaging citizens, in particular, marginalized populations and SRHR organizations while framing UHC legislation, policies, plans, financing arrangements and budgets; and the creation or active support of social accountability processes and mechanisms for community members, civil society, professional bodies and research institutions to hold the government to account at multiple levels of the health system.
- 2 Performance:** governments holding their own functionaries answerable internally for implementing SRHR sensitive UHC plans (including maternal death reviews, SRH scorecards and health facility committees).
- 3 Financial:** tracking and reporting on allocation, disbursement and utilization of financial resources, using the tools of auditing, budgeting and accounting including budget tracking, budget analysis including gender budgeting and strategic purchasing for ensuring universal coverage of SRH services for the most marginalized. (See case study 9 on the role of strategic purchasing to strengthen the accountability of NGOs in Afghanistan).



Case study 9: Strategic purchasing to strengthen accountability and efficiency of contracted nongovernmental organizations and quality of service delivery in Afghanistan

Between 2003 and 2005, the Afghanistan Ministry of Public Health (MOPH) developed the Basic Package of Health Services (BPHS) to address the population's most immediate needs and the Essential Package of Hospital Services (EPHS) to provide referral support for BPHS. All interventions included in BPHS are evidence-based, low-cost and high impact with a focus on communicable diseases control and mother and child health. The MOPH is directly responsible for planning, monitoring, and overseeing the implementation of BPHS and EPHS.

The BPHS and EPHS are implemented through innovative approaches to contracting NGOs to provide primary, secondary and tertiary care which has led to some improvements in health outcomes. In 2019, the MOPH introduced strategic reforms specifically in relation to the service delivery model, changing it from a narrow contract management to a performance management approach that includes Pay for Performance (P4P). This change was motivated by a need for improved accountability and efficiency of contracted NGOs and to enhance the quality of service delivery. The approach also included enhanced monitoring and active participation of Provincial Public Health Directorates and technical departments of MOPH, as well as third party monitoring which includes semi-annual Health Management Information System verification and health facility functionality analysis and annual drug quality assessment plus the periodic Afghanistan Health Survey.

Under P4P, payments to contracted NGOs are divided between a lump sum, where most basic and fixed costs should be estimated and a fee-for-service payment linked to 11 payment indicators, 5 of which are reproductive health-related. These indicators are being used as a base to evaluate the performance of the NGOs, low performance is followed by penalties for NGO service providers.

Despite the challenges of the humanitarian situation and high levels of insecurity in most parts of the country, the implementing of the P4P mechanism has showed substantial growth in service delivery in the second quarter and a partial improvement in the third quarter of 2019. However, concerns included the lack of understanding of the new rules by NGOs and that in some provinces the lump-sum payment fell below what was required to cover basic and fixed costs. As a result, workers of some NGOs went without salaries for months. Medicine procurement was also affected, and some NGOs reported having cheap and questionable quality local suppliers.

More recently, the COVID-19 pandemic has affected the delivery and utilization of essential health services, with adverse consequences for key health indicators in the coming months. For COVID-19 service delivery, the NGOs have received direct and separate contracts with the support of donors from an additional fund to respond to COVID-19 for the population in their respective provinces while keeping the normal essential service delivery in place.

Source: Safi and Naseri (2022).

Monitoring and evaluation framework for strengthening accountability in sexual and reproductive health service policy and implementation

SRH policies and strategies should include an M&E and review platform which outlines what must be monitored and evaluated, roles and responsibilities, measures for strengthening M&E capacity and a budget. There should also be alignment of M&E and

review in SRH policy and strategy with a national health policy or strategy if it exists. Table 1 provides guidance for the adaptation of and the elements for effective M&E and review outlined in WHO (2011) towards SRH policies and strategies.

Table 1: Key elements and considerations in developing a monitoring and evaluation framework for strengthening accountability in sexual and reproductive health policy and implementation⁹

Stakeholders, roles and responsibilities	Describes a transparent, participatory process involving key stakeholders. Stakeholders may include health policy-makers, planners, service providers, civil society organizations, community members, citizens forums, non-profit health providers and local governments.
	Includes multi-stakeholder forums for monitoring and evaluating SRH service provision and reproductive rights promotion in the context of UHC at national, provincial, district, and sub-district levels.
M&E indicators	Includes core indicators for monitoring SRH taking into account existing global and regional agreements, commitments and the SDGs (19) and identified targets.
	Includes UHC related indicators on service coverage and financial protection ¹⁰ and quality of services disaggregated by sex and other markers of context-relevant inequities such as race, ethnicity, disability, location and migratory status, that are acceptable and feasible.
	Includes qualitative and process SRH-UHC indicators linked to both national (for instance, legislation and regulation to support quality SRH in UHC is in place, comprehensiveness of SRH services in health benefit package and financing arrangements to ensure that they do not contribute to catastrophic expenditure) and sub-national levels.
Data and information systems to support M&E	Specifies types of quantitative and qualitative data, data sources including Health Management Information Systems, household surveys, patient exit interviews, vital registration and focus group discussions, and responsibilities for data collection.
	Identifies data gaps and how they will be addressed.
	Includes plans for strengthening and upgrading information systems (especially a functioning civil registration system and vital statistics) necessary for monitoring progress made towards achieving agreed targets disaggregated by sex, age, income, location and other markers of inequity.
Use of M&E findings in reviews and action	Includes how findings from M&E will feed into reviews by the relevant ministries, civil society and other stakeholders and how their capacity to analyse and use the findings will be ensured.
	Includes how findings will reach relevant citizen's groups, media, local government, professional bodies and private sector to enhance answerability of policymakers, planners and service providers.
Frequency of M&E and review	Specifies the frequency of M&E and review taking into account that monitoring should occur alongside SRH policy and programme implementation, monitoring reports should feed into annuals reviews for corrective action and valuations may be formative (for developing a programme) or summative (to make judgements about the efficacy of a programme).

⁹ For related SRH-UHC related indicators, see WHO and World Bank, 2017.

¹⁰ SDG Target 3.8 has two indicators – 3.8.1 on coverage of essential health services and 3.8.2 on the proportion of a country's population with catastrophic spending on health, defined as large household expenditure on health as a share of household total consumption or income (15).



Case study 10: Universal progress reviews and universal health coverage laws acting in synergy to promote comprehensive, affordable and quality sexual and reproductive health services in the Philippines

The Universal Progress Reviews (UPRs) were institutionalized in 2008 by the UN General Assembly as a mechanism for countries to report on their progress on human rights. The outcomes of these assessments by reviewing countries include a set of recommendations from the reviewing states, responses of the national government and any voluntary commitment by the state to follow the recommendations. The potential and challenges in using the UPR to promote SRHR is illustrated by the case of the Philippines, where the Family Planning Organization (FPOP) of the Philippines and Sexual Rights Institute lobbied in the UPR (2012) for a comprehensive SRH law and policy, legalization of abortion, age-appropriate sexuality education, better contraceptive services, posting an adequate number of midwives and conducting maternal death reviews (61). The reviewing countries recommended passing of SRH law legislation protecting rights of lesbian, gay, bisexual, transgender, intersex, or questioning persons (LGBTIQ), access to universal SRH services, enrolling the poor in health insurance, addressing GBV, strengthening family planning

services and providing abortion for rape, incest and risk to life of mothers (62). The Responsible Parenthood and Reproductive Health Act was passed in 2012, but as per the Working Group on the UPRs (2017) its implementation was uneven particularly for family planning and safe abortion services.

However, the SRH policy situation seems to have improved with the passage of the UHC law in 2019, which complemented the mandates specified in the reproductive health law for the Philippines to ensure universal access to reproductive health care and services including family planning. This development prompted the Department of Health (DOH) to widen its target population in its family planning programme from focusing narrowly on married women to all women including unmarried and sexually active women and, in particular, adolescents. Central to the mandates of the DOH under the UHC and RH law is the implementation of a holistic and life-stage approaches in its health programmes, integrating FP services in various health programmes such as maternal care and HIV care among others.

Source: Murthy and Gavino (2022).

Checklist for key accountability processes and measures for ensuring access to quality comprehensive sexual and reproductive health services

Effective accountability processes and measures towards access to quality comprehensive SRH services at a country level should be guided by the following questions (14,42,56,57,63):

1 Is there an enabling policy and institutional environment in place for ensuring effective accountability processes and measures which includes positive answers to the following questions?

1.1



Is there a strong and costed M&E plan (including at primary care level) as an integral component of the national SRH policy and strategy?



Is there a national committee or similar coordination and oversight mechanism tasked with M&E?



Are there multi-stakeholder committees or similar bodies inclusive of organizations representing communities, women, youth and minority groups as well as sound coordination mechanisms?

2 With regard to health information systems

2.1



Is it accessible to all citizens via a public dashboard?

2.2



Is data disaggregated by sex, age, income, geographic location and other context-relevant markers of equity to track progress?

3 With regard to M&E indicators

3.1



Are there selected core indicators for monitoring SRH and related targets considering existing global and regional agreements, commitments and the SDGs?

BACKGROUND

A

POLICY ACTIONS

B

IMPLEMENTATION

1

INCLUSION

2

ACTIONS

C

SERVICE DELIVERY

3

ACCOUNTABILITY

4

1.4



Are there mechanisms in place to ensure professional standards are upheld, that ensures that the health system does not mistreat or discriminate against people, and that has a particular focus on those who are vulnerable and marginalized seeking SRH services?

1.5



Is information collected from M&E activities used to inform amendments, corrective action or subsequent cycles of programmes or policies?

1.6



Are there inclusive transparent country mechanisms for review and action?

2.3



Are there robust health information systems that bring together relevant data from various sources that is publicly available and in usable formats?

2.4



Are there mechanisms that share information on SRH service package, financing, budgets, coverage of different populations, and quality and affordability of services in an easy-to-use and readily accessible manner?

3.2



Are there UHC-related indicators including at PHC-level (that is, service coverage, financial protection and quality of services) disaggregated by sex, age and other markers of context relevant inequities (for example, race, ethnicity, disability, location and migratory status) that are acceptable and feasible?

3.3



Are there qualitative and process SRH-UHC indicators in place (for example, legislation and regulation to support quality SRH in UHC, comprehensiveness of SRH services in health benefit packages, and financing arrangements to ensure that services do not contribute to catastrophic expenditure including at primary care level)?

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List of annexes

Annex 1: Why comprehensive sexual and reproductive health services are not fully integrated within health benefit packages

There are several reasons typically provided for why a comprehensive range of SRH services may not be included in health benefit packages.

- The prevalence of gender bias that influences how policy makers and governments address sexual and reproductive health and needs. This is especially the case for specific SRH services (including sexual health, abortion, contraception and violence against women) and specific groups such as adolescents, unmarried women, sex workers and migrant workers.
- Prohibitive or restrictive national laws and policies exclude the consideration of services in the health benefit package, seen for instance, in criminalization of abortion as well as services for LGBTIQ where same-sex relationships are illegal.
- Access to SRH services being linked to wider non-health benefits (for instance, women's economic and social empowerment), which are not always recognised in health sector priority setting processes, resulting in some instances in these services being undervalued. This is especially important if the selected decision-making criteria assign higher weight to considerations of value for money, with a focus on health outcomes alone, than considerations of equity and priority to the worse off, exhibiting bias against prioritizing interventions that are equitable and rights based.
- Priority setting processes are not transparent and inclusive of the wider group of SRH stakeholders including civil society, non-governmental organization (NGOs) women's groups, health care providers and programme implementers¹¹.
- A lack of sex parity and hierarchical systems contribute to not all stakeholders being heard, being able to influence the decision-making processes or having a voice in the selection of services (64,65).
- Weak or insufficient evidence being produced that is inadequate to support priority setting criteria because of a wider systemic challenge in the technical capacity available to generate evidence, or from the use of methods for generating evidence that are not suitable or appropriate such as only considering randomized controlled trials or evidence on human rights violations.
- Externally funded services being delivered as vertical programmes.
- The requirement for SRH services to include multisectoral action (for instance, comprehensive sexuality education).
- Being perceived to be outside the domain of the health sector, for instance, violence against women.

¹¹ The evidence indicates that in many priority setting processes, stakeholders are mainly limited to government, international donors, and national and international technical experts, with less involvement of communities and civil society organizations.

Annex 2: Assessment of health systems needs and examples of policy actions to implement sexual and reproductive health services

Assess health systems needs	Example of policy actions
<p>Health financing: to raise adequate funds so that people can use the required services and are protected from impoverishment through having to pay for them, as well as providing incentives for providers to perform efficiently.</p>	
<p>Is there a health benefit package in which SRH services are included and publicly funded?</p> <p>For SRH services outside of a health benefit package or in contexts where is none, what health financing systems are in place for reducing the financial barriers?</p> <p>What health financing prepayment systems are in place for ensuring financial protection for vulnerable and marginalized groups accessing SRH services?</p> <p>What is the impact of provider payment mechanisms on access, quality and efficiency of SRH services?</p>	<p>Inclusion of currently excluded SRH services within a health benefit package to improve financial access.</p> <p>Removal of user fees and co-payments in public facilities for SRH services and mechanisms to reduce demands for informal payments, as well as other hidden costs such as laboratory investigations, medicines and ambulances.</p> <p>Introduction of voucher schemes for reducing the financial barriers to access for vulnerable and marginalized groups (66).</p> <p>Introduction of performance-based financing to improve access to and quality of SRH services under strategic purchasing¹².</p>
<p>Human resources for health: to perform responsively, fairly and efficiently to achieve the best health outcomes given resources and circumstances.</p>	
<p>What is the current availability and capacity in the public, private and not-for-profit sectors, (i.e. quantity, distribution, competencies, skills, management, supervision) of human resources needed to provide prioritized SRH services?</p> <p>What is the current state of the working environment of health workers, particularly those at the frontline such as community health workers, nurses and midwives?</p>	<p>Upgrade existing nursing and midwifery schools to increase enrolment and staffing (67).</p> <p>Promote supportive supervision as a tool to empower health care providers, decent working conditions and introduce incentives for workers (including career development) and rotation between different geographic locations and levels of care (68).</p> <p>Ensure through both pre- and in-service training, that the health workforce tasked with the provision of SRH services are familiar with national guidelines and protocols relevant to their work.</p> <p>Consider the feasibility and potential added value of shifting SRH tasks among carers (51) while redressing the unpaid and underpaid nature of the care work done by the primarily female health workforce including community health workers (69).</p> <p>Ensuring the integration of gender equality and rights content as well as content on VAW response in pre-and in-service training curricula for health workers delivering SRH services (70).</p>

¹² Strategic purchasing “involves linking the transfer of funds to providers, at least in part, to information on aspects of their performance or the health needs of the population they serve” (71).

Assess health systems needs	Example of policy actions
<p>Service delivery: delivering effective, safe and quality interventions for improving SRH status among those most in need.</p>	
<p>Taking into consideration country-context (i.e. SRHR needs of population, national policies and legislation, international guidelines and commitments), what are the existing SRH service delivery models and approaches (including PHC and community-based delivery, non-for profit and private sector providers) and functioning referral systems between different levels?</p>	<p>Expanding engagement with private sector for provision of SRH services for adolescents through social franchising networks.</p> <p>Integrate gender-sensitive codes of conduct and training programmes for ensuring that SRH services, including self-care, are delivered based on respectful, quality and ethical care and the specific needs of all people based on human rights standards (72).</p> <p>Introduce digital tools to facilitate tracking of client health status and services, combined with decision support and targeted client communication e.g. SMS-based health behaviour change messaging (73)¹³.</p> <p>Introduce digital stock notification and commodity management that could contribute to the availability of commodities and equipment essential for SRH services (e.g. contraceptive methods) (73).</p> <p>Create social accountability processes to ensure health system responsiveness to community concerns about service delivery quality.</p>
<p>Medicines and technologies: to ensure equitable access to essential medicines, products and technologies that are of assured quality, safety, efficacy and cost-effectiveness.</p>	
<p>What is the availability and affordability of existing SRH medicines and technologies?</p> <p>What is the current status of commodity procurement and supply logistics for SRH medicines and technologies?</p>	<p>Introduce or strengthen existing policies to ensure a sufficient stockpile of essential SRH products including specific products needed by women and girls with improved procurement and supply chain structures.</p> <p>Introduce or strengthen existing policies that reduce the amount of out-of-pocket spending on SRH medicines and health technologies.</p> <p>Ensure that essential SRH medicines on the WHO Model List of Essential Medicines are included in national essential medicine lists, aligning with the global commitments to access to UHC and SRHR.</p>
<p>Health information: to produce, analyse, communicate and use reliable and timely information on health system performance, as well as health determinants and status.</p>	
<p>Does the existing health information system have the capacity to provide accurate, reliable and timely information? And is this knowledge for clinical management, financing, planning, and implementation applied so as to advance the national SRH and UHC priorities when responding to public health emergencies?</p>	<p>Strengthen information systems to generate and provide disaggregated data (i.e. income, sex, age, race, etc.) to allow for analyses of inequities in service delivery and access, and the quality of care of SRH services with a special focus on vulnerable and marginalized populations through Maternal Death Surveillance and Response (MDSR) audits and similar approaches.</p> <p>Strengthen the capacity of health systems to monitor and track out-of-pocket expenditure on SRH medicines and diagnostics in both the public and private sectors, disaggregated by sex, socio-economic status and other markers of equity.</p> <p>Ensure that information systems collecting data are able to keep and report data in a safe and confidential manner as many of the issues related to SRHR, such as women seeking abortion or violence against women, for which information is recorded can lead to potential harm.</p>

¹³ Important to ensure that tracking of clients do not violate their privacy and safety (for example, women seeking an abortion). Also, SMS based messaging needs to account for the fact that women and young people may not have private and safe access to mobile phones and hence, such communication must consider their safety.

Annex 3: Indicators illustrating the monitoring and evaluation of the implementation of sexual and reproductive health services in national health strategies and plans

Process indicators	Output indicators	Outcome indicators	Impact indicators
<p>National coordinating mechanism established to oversee development and implementation of the SRHR in national health policies and strategies</p> <p>Existence of national policies that promote equitable and affordable access to SRH services</p> <p>Evidence of youth involvement in the development and monitoring of the implementation of adolescent SRHR policies</p> <p>Evidence of capacity strengthening for women, youth and other vulnerable and marginalized groups to participate in policy decision making, implementation and monitoring processes</p>	<p>Percent of service delivery points providing post-abortion care services that meet a defined standard of quality</p> <p>Percent of health units with at least one service provider trained to care for and refer GBV survivors</p> <p>Existence of a human resource training strategy based on needs assessments to improve quality of childbirth, at an institutional level, adhering to respectful care and dignity</p> <p>Number of facilities with available stocks of emergency contraceptive</p>	<p>Service uptake by underserved or marginalised groups</p> <p>Evidence of client satisfaction</p> <p>Levels of out-of-pocket payments for SRH services that are not covered under a health benefit package or an insurance scheme by adolescents, migrants, and the very poor</p> <p>Percentage of adolescent girls who report having received an HPV vaccination</p>	<p>Maternal mortality disaggregated by socio-economic status, location, ethnicity, etc.</p> <p>Incidence of impoverishment because of health payment for childbirth</p> <p>Percentage of women of reproductive age who have experienced physical violence by family members in the past year</p> <p>Percentage of girls and women aged 15–49 years who have undergone FGM</p>



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