This draft working paper considers sexual and reproductive health and rights in the context of the post-2015 framework.

**Sexual and Reproductive Health and Rights and Global Development Goals**

There is a long-established consensus recognizing the importance of addressing sexual and reproductive health and rights. Twenty years ago at the International Conference on Population and Development in Cairo, governments recognized the central role of sexual and reproductive health and rights for both guaranteeing women’s equality and empowerment and development. The current Millennium Development Goals recognize the importance of reproductive health for development: target 5(b) under the goal to improve maternal health aims to achieve universal access to reproductive health by 2015. The UN Secretary-General’s Every Woman, Every Child initiative has further galvanized momentum toward achieving MDG 5.

More recently at the Rio+20 conference on sustainable development, governments called for the “full and effective implementation of the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development, and the outcomes of their review conferences, including the commitments leading to sexual and reproductive health and the promotion and protection of all human rights in this context” and “emphasize[d] the need for the provision of universal access to reproductive health, including family planning and sexual health, and the integration of reproductive health in national strategies and programmes.”

Despite the international consensus, progress in addressing sexual and reproductive health and rights and achieving international targets on these issues has been mixed. While there has been a substantial decline in maternal deaths over the past twenty years of about 50% since 1990, only 9 of 74 low and middle income countries that were recently reviewed by the Countdown to 2015 initiative are on track to meet MDG 5. Universal access to reproductive health services, including family planning, skilled antenatal, delivery, postnatal and emergency obstetric care, sexuality and reproductive health information and education, safe abortion services, and diagnosis and treatment of reproductive tract infections and cancers, among other services, continues to be a distant goal.

**Sexual and Reproductive Rights and Health and Universal Health Coverage**

One issue that has received much attention as discussions around the post-2015 development framework have accelerated is universal health coverage. Universal health coverage is commonly defined as “a system in which everyone in a society can get the health care services they need without incurring financial hardship.” Universal health insurance is a critical factor in achieving universal health coverage, because of the role it can play in providing financial protection against catastrophic health costs. The right to health and uptake of health care are other essential elements, of achieving universal coverage, but generally receive less attention than the financing aspects.

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The design of health insurance schemes can have major implications for women and girls and can either facilitate or impede access to sexual and reproductive health services. Considerations of who is covered; what services are covered; the extent of financial protection; and confidentiality and privacy in the provision, documentation and billing of services, all need to be taken into account to ensure that the financial barriers faced by women and adolescents are addressed.

Certain types of insurance programs are more likely to reach women, particularly poor and marginalized women, than others. Compulsory social insurance schemes that are linked to formal employment may exclude from coverage large proportions of women globally who work in the informal sector, or do not participate in waged employment. Community-based health insurance schemes, often seen as a stepping stone for the poor and those employed in the informal sector to universal health coverage, might still exclude poor women or women who have limited control over or access to cash, despite the low premiums. Indeed, there is increasing evidence that community-based health insurance schemes may be regressive for poor households, especially if premiums are not assessed on the basis of ability to pay; something which in practice has proven difficult to implement.

On the other hand, social protection health insurance schemes that target poor and marginalized women with no-fee services or conditional cash transfers that simultaneously incentivize health-seeking behavior and address the costs associated with care may facilitate access to services for poor women. In both cases, women who are above the poverty line but still face financial constraints, adolescent girls, and older women may still fall through the cracks due to a number of reasons including lack of autonomy and decision-making power, or lack of information.

Health services that are essential for women, including family planning counseling and contraceptives; prenatal, delivery, postnatal and emergency obstetric care; safe abortions; STI diagnosis and treatment; prevention, diagnosis and treatment of reproductive tract cancers; and other sexual reproductive health services, are often only partially covered by insurance schemes, or may be excluded from coverage altogether. A survey of 152 Essential Services Packages in the 1990s, which define services that are eligible for no-cost or low-cost coverage, found that only 20 included coverage for all of the following basic reproductive health services: family planning, antenatal care, delivery by trained attendants, postpartum care, and emergency obstetric care. In countries with parallel insurance schemes covering different segments of the population, differences in the services covered may result in inequities in access to sexual and reproductive health care. For example, Thailand’s Universal Coverage program, which covers more than 45 million, covers a comprehensive set of sexual and reproductive health services, increasing access for millions who were previously uninsured. However, the parallel SSS insurance scheme, which covers more than 10 million private sector employees in the country, does not cover family planning, menopause services, or diagnosis and treatment reproductive tract infections, including HIV, and provides only partial coverage of reproductive tract cancers.

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6 Ravindran TK Sundari (2012)
7 Ibid.
In many places, what is and is not covered by health insurance programs may be deeply political. In most countries, safe abortion services are rarely covered by public insurance programs, despite the fact that they are legal on at least one or more grounds. In the United States, for example, federal law prohibits coverage of abortion services for women with Medicaid, except in the cases of rape, incest, or where the pregnancy threatens the health or life of the pregnant woman. Coverage of contraceptives and sexual health services for adolescents may be likewise constrained due to political sensitivities.

The level of financial protection offered by insurance schemes also varies. There is substantial evidence that women consistently experience a higher burden of out-of-pocket costs for health care services than men who have similar levels of insurance coverage, largely due to non-coverage or limits on coverage for sexual and reproductive health services. In Thailand, although comprehensive maternity care is a part of the universal coverage benefit package, only the first two pregnancies and deliveries are covered, meaning that women shoulder an additional financial burden if they have more than two children. Even nominal co-pays as a requirement for accessing care, common in many insurance programs, may also pose a significant barrier if women do not have access to or control over cash.

Concerns about the confidentiality and privacy of insurance users may also impede access to services for those with insurance. For example, in the United States adolescent girls and boys and young women and men who are enrolled as dependents under their parents’ health insurance policies often forgo using their insurance coverage to access and pay for sexual and reproductive health services, for fear that their parents will see explanation of benefits or billing statements from their insurance companies that disclose that they sought such care. To illustrate the resulting gap: 90% of insured women over 30 who obtained contraceptive services in 2002 used their insurance to cover their care; but only 68% of insured adolescent girls and 76% of insured young women (age 20-24) did. Instead, many young women and men seek care from publicly funded or subsidized services or pay directly for the services out of pocket. Women covered as dependents under their husbands’ insurance policies, may likewise be hesitant to seek much-needed care if they do not want their husbands to know, such as contraceptives or treatment for violence.

Health insurance programs that work for women are those that:

- Extend beyond those employed in the formal sector and enable women who are single, young women, elderly women, or employed in the informal sector to participate and obtain coverage.
- Are fully funded by public sources or involve only nominal premiums that do not pose an additional financial barrier for women.
- Ensure free services at the point of care.
- Cover a wide range of sexual and reproductive health services, including the provision of sexual and reproductive health information and education; family planning counseling and contraceptives; safe abortion services; antenatal, delivery and postnatal care; diagnosis and treatment of sexually transmissible and other reproductive health tract infections; diagnosis and treatment of reproductive tract cancers; and sexual and reproductive health services for menopausal, elderly and adolescent women.

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10 Ravindran TK Sundari (2012)
13 Ibid, 5.
• Guarantee confidentiality and privacy.

**Addressing other Barriers to Sexual and Reproductive Rights and Health**

While the affordability of and other economic barriers to access pose formidable obstacles in meeting the sexual and reproductive health needs of women and girls, universal health coverage alone is not sufficient for meeting women’s and young people’s sexual and reproductive health needs and guaranteeing their sexual and reproductive rights. Other factors that are just as critical in whether or not women and young include whether services are acceptable, available, geographically accessible, and of acceptable quality.

In Ghana, for example, between 2004 and 2007, the three years following the introduction of national health insurance, there was no overall increase in deliveries that took place in health facilities accompanied by skilled attendants (although women with insurance were more likely to deliver in facilities than women without insurance). This suggests that non-economic factors play a significant role in women’s decision-making about whether to use skilled care at childbirth.\(^\text{14}\)

Barriers exist for women and young people to sexual and reproductive health services, and exercising reproductive rights, stem from:

- **Laws and policies** that have consequences on women’s and young people’s ability to access and use services, such as policies requiring parental or spousal consent or couples treatment, or laws that restrict the provision of and access to certain services, such as safe abortion.

- **Social and cultural norms and practices**, including gender inequality and discrimination against women and girls, which can manifest in the deprioritization of immunizations for girls in countries where son preference is prevalent, or stigma and discrimination against unmarried women seeking sexual health services in health facilities. They result in poor quality of care and can reduce uptake even when services are otherwise available;

- **Lack of individual empowerment, information, and education**, which can impede women’s and adolescent’s knowledge about health and health-seeking behaviors;

- **Weaknesses in health systems** that may result in inaccessible, inadequate, and/or inappropriate services, and/or poor quality of care. These include for example, inequitable distribution of services between urban and rural areas; insufficient numbers of trained health care workers of different cadres; lack of gender-sensitized health workers; and lack of services targeted towards meeting the specific needs of women, men, people of other genders; and

- **Other social determinants of health**, such as poverty, food and nutrition security, water and sanitation, and other environmental and occupational factors, which have can have specific negative health consequences for women and girls, including for their sexual and reproductive health.

Without concomitant efforts to address these factors, women and girls, will continue to face challenges accessing and using sexual and reproductive health services and exercising their reproductive rights.

Increasing evidence demonstrates that most effective programs in meeting women’s and young people’s sexual and reproductive health needs are those that include a mix of interventions to address multiple barriers to care at once. Many of these are context specific and, as such, require the

\(^{14}\) Health Systems 20/20 Project and Research and Development Division of the Ghana Health Service (2009). An Evaluation of the Effects of the National Health Insurance Scheme in Ghana. Bethesda, MD.
involvement of women and adolescents in the design and delivery of programs to ensure that the goal of increasing access to sexual and reproductive health services is achieved.

**SRRH and the next development framework**

Guaranteeing women’s and adolescents sexual and reproductive rights and health is critical, not just for improving overall population health, but for economic development and growth, environmental sustainability, and gender equality and women’s empowerment. Universal health coverage alone is not enough to guarantee access to these services, not least because many of the obstacles to sexual and reproductive health care are rooted in persistent gender inequality and the marginalization of women. Instead, specific programs focused on addressing the diversity of barriers to access are needed, along with a dose of political will and adequate resources. It is for these reasons that the next development framework should build on these agreements prioritize universal access to reproductive health and protection of sexual and reproductive rights.

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