IPPF

From
the People of Japan

HEALTH FOR ALL
UNIVERSAL HEALTH COVERAGE COALITION

Leaving no one behind

Universal health coverage and sexual and reproductive health and rights

Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

IPPF works towards a world where women, men and young people everywhere have control over their own bodies, and therefore their destinies. A world where they are free to choose parenthood or not; free to decide how many children they will have and when; free to pursue healthy sexual lives without fear of unwanted pregnancies and sexually transmitted infections, including HIV. A world where gender or sexuality are no longer a source of inequality or stigma. We will not retreat from doing everything we can to safeguard these important choices and rights for current and future generations

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A collective group of IPPF secretariat staff have contributed to the content and reviewed the report. They are: Amardeep Kamboz, Elias Girma, Erica Belanger, Hiroko Takasawa, Jameel Zamir, Lawrence Oteba, Manuelle Hurwitz, Natassha Kaur, Raffaela Dattler, Riva Eskinazi, Sarah Onyango, Seri Wendoh, Yilma Melkamu and Yuri Taniguchi.

Design: Sue MacDonald; Edit: Mags Allison.

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Key abbreviations

AFGA	Afghan Family Guidance Association
CSE	Comprehensive sexuality education
FGAE	Family Guidance Association of Ethiopia
FGM	Female genital mutilation
FHOK	Family Health Options Kenya
GBV	Gender-based violence
GDP	Gross domestic product
HIV	Human immunodeficiency virus
IDP	Internally displaced person
IPES	Integrated Package of Essential Services
IPPF	International Planned Parenthood Federation
LMIC	Low- and middle-income countries
NGO	Non-governmental organization
NHA	National health accounts
NHIF	National Health Insurance Fund
PHC	Primary health care
RHAC	Reproductive Health Association of Cambodia
SDG	Sustainable Development Goal
SFPA	Sudan Family Planning Association
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
UHC	Universal health coverage
WHO	World Health Organization

Contents

Foreword

Ministry of Foreign Affairs, Japan

Universal health coverage (UHC) means that all people can obtain basic health services when they need them without suffering financial hardship. In 1961 Japan introduced universal health insurance coverage and established a basic health service system, enabling all Japanese citizens to access basic health services when they needed them and at an affordable cost. In other words, it achieved universal health coverage and this system has been sustained for more than half a century. It was one of the main reasons Japan achieved the world's highest life expectancy, and realized the development of a stable society with a relatively small income gap between the rich and the poor.

The Government of Japan identified UHC as one of its basic policies in its guidelines for global health policy, both in Japan's Strategy on Global Health Diplomacy (2013) and Basic Design for Peace and Health (2015). Japan has been promoting UHC to enable all people, including the poor, to access basic health services in collaboration with the global community, and has contributed to making UHC – encompassing access to quality basic health services such as reproductive health services – one of the targets of the Sustainable Development Goals (SDGs), set out in the 2030 Agenda for Sustainable Development. Furthermore, universal access to sexual and reproductive health care services for all, including the poor, became two independent SDG targets (SDG3.7 and SDG5.6).

As the world faces various health challenges such as maternal and child health and ageing, it is necessary to secure health services people can access throughout their life cycle. For many years, the Government of Japan has mobilized its expertise, wisdom and creativity to respond to sexual and reproductive health challenges together with partner organizations. This is because Japan believes that sexual and reproductive health is important to protect and empower individuals and enable them to reach their full potential, which is 'human security'. In order to achieve these shared goals, it is necessary that national governments, international organizations and civil society collaborate in strong partnership.

Dr Manabu Sumi
Director, Global Health Policy Division
International Cooperation Bureau

International Planned Parenthood Federation

Universal access to sexual and reproductive health and rights is critical to achieving universal health coverage and thereby the 2030 Agenda for Sustainable Development. IPPF, a locally owned, globally connected movement for change in sexual and reproductive health and rights, supports countries to achieve universal health coverage through promoting sexual and reproductive health and rights for all, particularly focusing on reaching poor, young and other vulnerable groups who face discrimination and other barriers in realizing their rights.

This report, *Leaving no one behind: Universal health coverage and sexual and reproductive health and rights*, demonstrates to partners and wider stakeholders working towards the 2030 Agenda for Sustainable Development the crucial importance of sexual and reproductive health and rights in achieving universal health coverage. It elaborates on the Summary Report published in December 2017, with further information on the issues, progress made and current gaps, and provides updates based on May 2018's report of the Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights.

Leaving no one behind also discusses IPPF's contribution towards universal health coverage. Case studies of the work of IPPF Member Associations illustrate the realities on the ground and good practices in achieving universal access to sexual and reproductive health and rights. These efforts have contributed to strengthening national health systems, empowering communities, and reaching the poorest, most vulnerable and marginalized with quality and rights-based services.

I would like to express my sincere appreciation to the Government of Japan for its long-standing support to IPPF and for being such a strong world leader in global health, particularly in the promotion of universal health coverage and human security. It is through the Japan Trust Fund that IPPF Member Associations have been able to implement innovative and life-changing projects such as those presented in this report and contribute to realizing universal health coverage in their countries.

Dr Alvaro Bermejo
Director General

Summary

To inform the sustainable development community, IPPF commissioned a literature review looking at progress to date in and challenges to achieving universal access to sexual and reproductive health and rights. The resulting report highlights sexual and reproductive health and rights as an essential contributor to UHC, illustrated with case studies from IPPF Member Associations.

Background

Universal health coverage (UHC) means ensuring every person has access to quality, affordable health services, and plays a pivotal role in achieving the Sustainable Development Goals (SDGs). Healthy populations can better contribute socially and economically, while poor health is a major driver of poverty.

Underpinning the aim of UHC is the human right to health, of which sexual and reproductive health and rights are an integral part.[1,2] Universal access to sexual and reproductive health is highlighted in the SDGs as a driver to ensure healthy lives and well-being (Goal 3) and to achieve gender equality and women's empowerment (Goal 5). Furthermore, a monitoring indicator of the UHC target explicitly includes reproductive health services as part of a package of essential health services.

Despite this, there is often incoherence between the aim of UHC and its implementation. Comprehensive sexual and reproductive health services must be provided as a centrepiece of UHC both to protect gains and to accelerate progress towards other SDGs.[3]

Results of the review

Coverage of sexual and reproductive health services

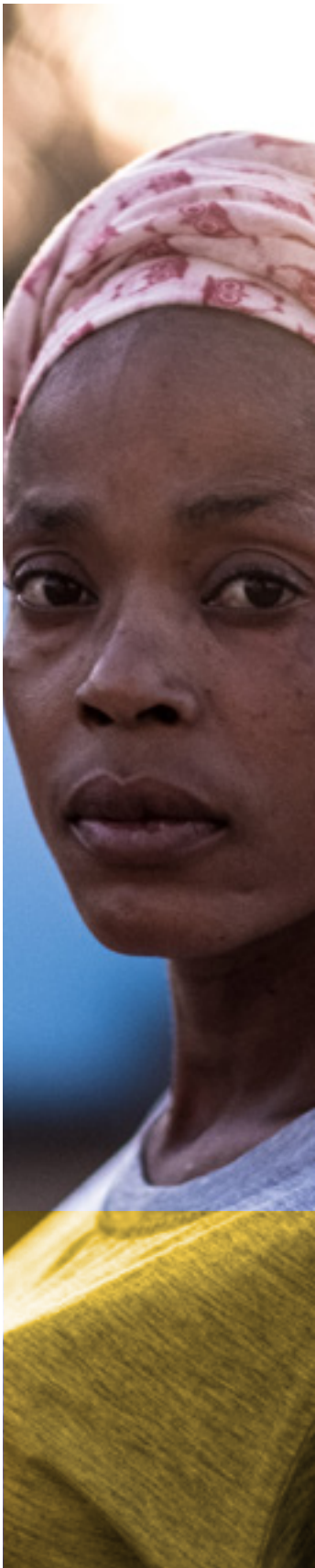
Despite the high need, the health service package offered in many developing countries only addresses a limited number of sexual and reproductive health services. Additionally, it is not always sensitive to the diverse needs of people who face social and economic challenges.

Financial protection and expenditure on sexual and reproductive health services and goods

Financial protection schemes usually increase service use.[4,5,6] However, although insurance schemes or tax-funded health services exist in many developing countries, populations or services covered are limited.[7] Provision of adequate, accessible and comprehensive sexual and reproductive health services through financial protection would substantially improve the health of women and children, and reduce the burden on already overwhelmed health systems. Currently, individuals pay a significant proportion of spending on sexual and reproductive health services. Mobilizing domestic resources in support of these services is essential to reduce the substantial inequity in out-of-pocket expenditure that exists.[8,9]

Sexual and reproductive rights to advance towards UHC

How the commitment to UHC has been put into practice varies greatly.[10] Even in high-income countries UHC is inadequate and does not cover comprehensive sexual and reproductive health services. The resources allocated often do not address the needs of vulnerable and marginalized populations, who also face stigma and discrimination, further limiting access to services. Evidence shows that a rights-based approach to health leads to more equitable health outcomes[11] and builds resilience and sustainability into UHC.



Conclusions

Ensuring sexual and reproductive health rights for all yields high returns for sustainable development. Without this, countries will not be successful in reducing inequalities, in stimulating and sustaining economic growth, or in ensuring environmental sustainability.

Providing affordable, accessible, acceptable, and quality sexual and reproductive health services covered by financial protection schemes reduces both financial hardship and health inequity. Moreover, investing in sexual and reproductive health is one of the most cost-effective health interventions.

UHC must be considered within a broader framework to address the underlying social determinants of health and make health systems fully functional and free of social and economic barriers. Without including sexual and reproductive health information and services as part of universally available and affordable essential health services, we would not see progress towards UHC, nor would we ensure the right to health for all and leave no one behind.

IPPF contribution to UHC

IPPF and its Member Associations address obstacles that limit vulnerable and marginalized populations' access to services by challenging discrimination and advocating for policies that ensure universal access to information and services. Recognizing the financial burden of out-of-pocket healthcare expenditure, IPPF Member Associations' 'no-refusal policy' ensures that all clients receive services, regardless of their ability to pay.

Through its Member Associations IPPF also contributes to strengthening national health systems, such as by training government healthcare workers and supplying contraceptive commodities. IPPF is committed to tackling the social determinants of health and upholding the sexual and reproductive rights of the vulnerable and marginalized, thus contributing to UHC. Case studies of IPPF Member Associations in Afghanistan, Kenya, Cambodia and Sudan provide practical examples of this work.

Introduction and background

Universal health coverage and sexual and reproductive health and rights are vital for sustainable development

Universal health coverage (UHC) – ensuring every person has access to quality, affordable health services – plays a pivotal role in achieving the Sustainable Development Goals (SDGs) through improving the health and well-being of people of all ages. The return for each dollar invested in health services across the life course of a person is estimated to be about US$10.[12] Healthy populations can better contribute socially and economically, leading to higher returns to individuals, communities and societies. In contrast, poor health is a major driver of poverty. Every year, more than 100 million people fall into poverty due to out-of-pocket spending on health.[13]

Universal access to sexual and reproductive health is highlighted in the SDGs as a driver to ensure healthy lives and well-being (Goal 3) and to achieve gender equality and women's empowerment (Goal 5). Furthermore, a monitoring indicator of the UHC target explicitly includes reproductive health services as part of a package of essential health services. Despite these goals and targets, there is incoherence between the aim of UHC and its implementation, and large gaps in achieving universal access to sexual and reproductive health services and UHC. Sexual and reproductive rights are not referenced in these goals, and national health care service packages designed to promote UHC often do not include essential sexual and reproductive health services.

While UHC is supposed to be a commitment underpinned by the fundamental human right to health, including sexual and reproductive health and rights, the progress monitoring framework created by the key actors of UHC narrowly focuses only on coverage of population by a limited number of health services and financial protection. The right to health for all, on which UHC should be grounded, has not been at the centre of discussions on UHC. Comprehensive sexual and reproductive health services must be provided as a centrepiece of UHC both to protect gains and to accelerate progress towards other SDGs.[14] People of all ages around the world must be able to realize the right to health, which includes sexual and reproductive freedom, and other basic human rights related to family life and participation in social, economic and public spheres.[15]

Sexual and reproductive health and rights (SRHR) are essential for sustainable development because of their links to gender equality and women's wellbeing, their impact on maternal, newborn, child, and adolescent health, and their roles in shaping future economic development and environmental sustainability.

Source: Guttmacher-*Lancet* Commission 2018[16]

To inform the sector and wider stakeholders working on sustainable development, IPPF commissioned a literature review on the importance of sexual and reproductive health and rights in achieving UHC. The study focused on publications addressing progress so far in and challenges to achieving universal access to sexual and reproductive health and rights. For full details of the methodology, see page 9.

This report discusses the links between sexual and reproductive health and rights and UHC in terms of reaching the SDGs, synthesizes the literature from the review and shows the work of IPPF Member Associations in their countries.

Universal health coverage

The World Health Organization (WHO) defines UHC as all people having access to essential health information and services (promotive, preventive, curative and rehabilitative) of sufficient quality to cover their various health needs, without people suffering financial hardship to pay for these services.[17] Three dimensions – the proportion of the population to be covered, the range of services to be made available, and the proportion of the total costs to be met – are often represented as the UHC cube.[18] It conceptualises the journey towards UHC as a task of making progress along expanding each of the dimensions *towards* 100% to help 'fill' the cube.

According to the latest UHC tracking report, at least half of the world's population cannot obtain essential health services.[19] The majority of health expenditure derives from out-of-pocket expenditure in low-income countries (53%), while it accounts for 22% in high-income countries.[20] Each year, a large number of people are being pushed into poverty because they need to pay for health care out of their own pockets. High out-of-pocket expenditure prevents the poor and marginalized from seeking care. To tackle these challenges, UHC aims to provide health care based on need, irrespective of a person's ability to pay. The key to protecting people from financial hardship is to ensure that most funds for a health system are prepaid, and that services are purchased from these pooled funds in a way that limits the need for people to pay for services out-of-pocket at the time of use.[21]

The ultimate aim of UHC is to realize a fundamental human right, *the right to health*, which is the right to enjoy the highest attainable standard of health.[22,23,24] The right to health covers more than the right to health care: it includes the right to control one's health and body, including sexual and reproductive freedom, without discrimination.[25] The 2013 *World Health Report* highlights that UHC must be situated within a broader framework to address the underlying social determinants of health. Tackling the determinants both within and outside health systems builds an enabling environment where all individuals can fulfil their right to health regardless of gender, age, race, ethnicity, language, religion, disability, marital status, health status (including HIV status), sexual orientation and economic status. The right to non-discrimination and equality is also a core principle of the SDGs, as indicated in the central pledge, 'leaving no one behind'.[26]

Countries must also take actions beyond the health sector to change social norms, laws, and policies to uphold human rights. The most crucial reforms are those that promote gender equality and give women greater control over their bodies and lives.
Source: Guttmacher-*Lancet* Commission[27]

While equity is a key component, the current focus of UHC is inclusion through removing financial obstacles by monitoring coverage of services and financial protection. This limited focus may divert attention from other forms of exclusion.[28] The current monitoring indicators for UHC usually disaggregate coverage of services by a limited set of population characteristics such as education, place of residence or wealth, which is not sufficient to monitor the progress in realizing the right to health of all segments of a population. Monitoring coverage gaps in UHC must include the assessment of gaps that arise from multiple forms of discrimination, which can stem from both within and outside health systems.[29] UHC must conform to the principles of the right to health and the SDGs, and give special consideration to ensure that all individuals, particularly those from the most vulnerable and marginalized groups, receive accessible, acceptable and quality care to meet their needs. In turn, this rights-based approach builds resilience and sustainability into health systems and improves health outcomes by addressing the underlying determinants of health.[30]

Sexual and reproductive health and rights

Sexual and reproductive health and rights are indispensable human rights and an integral part of the right to health, which underpins the aim of UHC. As discussed on page 13, the right to health cannot be enjoyed without ensuring sexual and reproductive health and rights and other human rights. States are legally obliged to realize the right to health by international laws.[31,32]

The International Conference on Population and Development (ICPD) Plan of Action broadly defines reproductive health as "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."[33] 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." Reproductive rights, according to the ICPD, "rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health." It is the right to have control over and decide freely and responsibly on matters related to sexuality – including sexual and reproductive health – free from coercion, discrimination and violence.

Sexual health refers to a "state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity." A positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences free from coercion, discrimination and violence is required for improving sexual health. The sexual rights of all individuals must be respected, protected and fulfilled to attain and maintain sexual health.[34]

In May 2018, the Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights published a report in which it presented an expanded and evidence-based comprehensive definition of sexual and reproductive health and rights. The report recommends that an all-inclusive package of essential sexual and reproductive health services and information should be available to everyone, and states that every individual has a right to make decisions that govern their bodies, free from stigma, discrimination, and coercion.[35]

The Commission's report addresses all three dimensions of UHC. The recommended package encompasses a range of sexual and reproductive health services, including those which are often overlooked, such as gender-based violence, comprehensive sexuality education (CSE), the prevention and treatment of sexually transmitted infections and reproductive cancers, counselling and care related to sexuality, sexual identity and sexual relationships, and safe abortion services. Women have historically been the focus of sexual and reproductive health interventions. While noting that much remains to be done to ensure their full access to sexual and reproductive health and rights overall, the report identifies specific groups who need

INTEGRATED DEFINITION OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

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

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

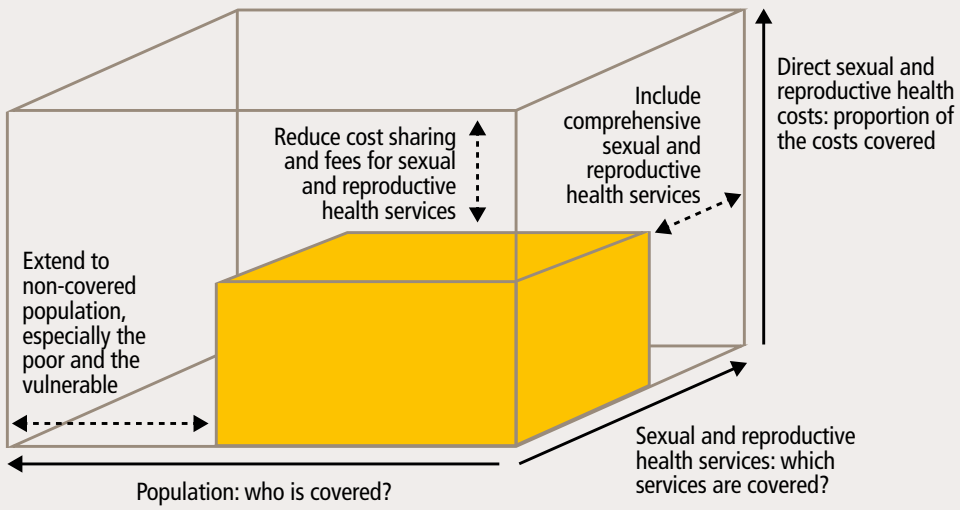
Source: Guttmacher-*Lancet* Commission 2018[36]

attention such as adolescents; people with diverse sexual orientations, gender identities and expressions, and sex characteristics; displaced people and refugees; and others with specific disadvantages. The report also notes the importance of involving men and adddressing their sexual and reproductive health needs.

The Commission reaffirms that realizing sexual and reproductive rights is essential to achieving sexual and reproductive health, and that barriers – especially gender inequality – embedded in laws, policies, the economy, and social norms and values need to be overcome.

As shown in the cube below, universal access to sexual and reproductive health services not only requires increasing population coverage but also providing comprehensive services and reducing costs incurred by individuals and households. In addition, UHC, which is underpinned by the right to health, will not be achieved without respecting, protecting and fulfilling sexual and reproductive health and rights. An approach which does not address barriers to sexual and reproductive health and rights, nor make comprehensive sexual and reproductive health information, goods and services available, accessible, acceptable, and of good quality to all, does not constitute the full implementation of UHC.

THREE DIMENSIONS TO UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH



Adapted from: WHO World Health Report 2010

Methodology

Corresponding to the main components and ultimate aim of UHC, IPPF commissioned a three-part literature review. Over 340 studies and documents were reviewed, focusing on published and unpublished literature that addresses progress and challenges in the following areas:

- population coverage with sexual and reproductive health services
- population coverage with financial protection in terms of meeting sexual and reproductive health needs, and expenditure on sexual and reproductive health services and goods
- right to health including sexual and reproductive rights.

The reviews were largely restricted to eight essential sexual and reproductive health services that are identified as the Integrated Package of Essential Services (IPES) by IPPF: 1) information/counselling for sex, sexuality and relationships; 2) provision of contraception and counselling; 3) safe abortion care; 4) STIs/RTIs testing and treatment; 5) HIV testing and counselling; 6) gynaecology including cervical cancer screening; 7) prenatal and post-natal care; and 8) screening and referral for gender-based violence (15).[37] This is not an exhaustive list of sexual and reproductive health services, but the eight services were selected to make the review feasible. Attention was also given to inequity in access to sexual and reproductive health services across different groups of populations.

In the first review on population coverage with sexual and reproductive health services, early literature searches using electronic databases yielded a large number of hits. The decision was made to search key relevant reports, studies and resources with Google Search as well as using the websites of key multilateral institutions (particularly WHO) and IPPF.

As evidence on financial protection and health expenditure in relation to sexual and reproductive health services and goods is relatively scarce, the second review conducted a systematic search to identify relevant original studies and systematic reviews. Studies published between 2010 and 2017 in English were searched using electronic databases Medline and POPLINE. Medline was searched using MeSH terms representing sexual and reproductive health and rights and the essential areas of sexual and reproductive health services described above;* combined terms related to financial protection and health expenditure† and names of all countries designated as low- and middle-income countries (LMIC) based on the World Bank's list. The POPLINE keywords that refer to the MeSH terms used in the Medline search were used in the search with POPLINE. Studies that did not focus on sexual and reproductive health and rights or one of the eight key essential sexual and reproductive health services, those with no relevant quantitative data, and studies focusing only on HIV treatment or maternal health (except prenatal and post-natal care) were excluded.

The third review on sexual and reproductive rights used Google Search to source key relevant reports and resources, largely from WHO, United Nations Population Fund (UNFPA) and IPPF, that focused on sexual and reproductive health and rights, right to health and rights-based approaches to health and sexual and reproductive health.

In all three searches, articles and documents referenced within the resources that were identified as relevant for this report were also reviewed.

In December 2017, a summary report was published based on the key findings of the literature review, illustrated by case studies from IPPF Member Associations. As IPPF prepared for the publication of its full report, on 9 May 2018 the Guttmacher-*Lancet* Commission on Sexual and Reproductive Health and Rights launched its report *Accelerate progress – sexual and reproductive health and rights for all,*[38] which supports and further strengthens the arguments contained here. This full report has, therefore, been updated with references to the Guttmacher-*Lancet* Commission report.

* The MeSH terms used in the search were "reproductive health", "reproductive rights", "sexuality", "contraception", "abortion, induced", "circumcision, female", "sexually transmitted diseases", "reproductive tract infections", "sex education", "HIV", "prenatal care", "postnatal care", "intimate partner violence", "reproductive health services", "family planning services", OR "adolescent health services"

† The MeSH terms, "health expenditures", "financing, government", "financing, personal", "healthcare financing", and a keyword "out of pocket expenditure" were used in the search

Results

Coverage of sexual and reproductive health services

More people have access to essential health services today than ever before. However, equity is a matter of concern and it is estimated that at least half of the world's population lacks access to essential health services.[39] Many studies consistently presented coverage disparities of the essential sexual and reproductive health services by wealth, age, educational level and place of residence (urban/rural).

Sexual and reproductive health services are critical in addressing the needs of diverse populations. To ensure universal access to sexual and reproductive health for all segments of a population, a rights-based approach to health is essential. Despite the high need for sexual and reproductive health services, and the explicit indication of reproductive health services in the UHC targets within the SDGs, the health service package offered in many developing countries as part of UHC only addresses a limited number of sexual and reproductive health services and is not sensitive to the diverse needs of population groups, such as young people and vulnerable and marginalized women and girls, who face particular challenges.

Progress in and challenges to access to essential sexual and reproductive health services and the persistent inequity of services across populations are discussed below.

Information for sex, sexuality and relationships

When implemented well, comprehensive sexuality education (CSE) improves knowledge, attitudes and behaviour towards sexual and reproductive health and contributes to reducing unintended pregnancies, transmission of HIV and other STIs, unsafe abortion and maternal mortality and morbidity.[40] People of all ages should be able to receive adequate and evidence-based information in and outside school without parental or third-party authorisation. However, while there are 1.2 billion people aged 15–24 worldwide, young people often have poor access to information and counselling for sex, sexuality and relationships. Young people have a range of sexual and reproductive health needs, but their access to quality sexual and reproductive health information and services such as contraception, HIV prevention and treatment, safe abortion care and sexual and gender-based violence is limited. Reasons for this include cultural practices, restrictive laws and stigma within their communities and among healthcare providers.

Provision of contraception

The unmet need for family planning continues to be unacceptably high despite various initiatives and policies that prioritise access to family planning services and commodities. Worldwide, an estimated 214 million women who want to delay or avoid pregnancy are not using a modern method of contraception.[41] Evidence shows that vulnerable and marginalized women and girls with the highest level of need for family planning include: (1) young women and adolescent girls aged 10–24 years; (2) women and girls living in hard-to-reach areas, particularly urban slums, street dwellers and displaced populations; (3) women and girls in the lowest income quintile (i.e. poorest 20%); (4) women and girls impacted by disability, gender-based violence and HIV; and (5) women and girls who are post-partum.[42]

Globally, between 1990 and 2015, the birth rate among adolescent girls aged 15–19 declined only slightly, from 59 births to 51 births per 1,000 girls. Unintended pregnancy among these groups leads to an elevated risk of subsequent school dropout and maternal mortality. The poor, the less educated, and women living in rural areas have a persistently higher unmet need for family planning than the least poor and more educated and those living in urban areas. The high level of unmet need indicates the limited ability to exercise rights to sexual and

reproductive health among women of reproductive age, particularly women from vulnerable and marginalized groups.

Safe abortion care

WHO estimates that each year 55.7 million abortions occur worldwide, of which 45% are unsafe. Ninety-seven per cent of the unsafe abortions globally occur in developing countries. There is stark inequity in the proportion of unsafe abortion between developing and developed countries. In developing countries, it is estimated that 49.5% of all abortions are unsafe, whereas in developed countries, this proportion is 12.5%.[43]

Unsafe abortion causes considerable negative consequences on women's health, and an unnecessary and substantial burden on health systems due to the complications it causes. A study in 2009 estimated that about seven million women in developing countries received treatment for complications resulting from unsafe abortions.[44] Yet, access to safe abortion care remains limited due to lack of services, restrictive legal frameworks and stigma surrounding abortion. The legal status of abortion and the availability of services does not affect abortion rates, rather it dramatically limits women's access to safe abortion care.[45] Limited access to safe abortion care means that many women, especially vulnerable and marginalized women, adolescents and poor women, seek abortion from unskilled providers.[46] Young people in particular face unique challenges when seeking abortion services and are disproportionately affected by stigma.[47] Unsafe abortion is easily preventable by increasing access to affordable and effective contraception and to safe abortion care.

Sexually transmitted infections

Sexually transmitted infections (STIs) have major health and economic impacts, and the consequences disproportionately affect women and children. Though the prevalent STIs – syphilis gonorrhea, chlamydia and trichomonas – are curable, STIs are one of the major causes of morbidity and mortality among women of reproductive age in LMICs.[48] Studies showed that delayed health care seeking or inadequate diagnosis and treatment of STIs resulted in high rates of STI and complications in LMICs.[49] Prevention including promotion of condom use and making testing and treatment more accessible and affordable would make a large difference in the burden of STIs and prevent people falling into poverty.

HIV

Significant progress has been made in HIV prevention and treatment over the past decades. Nevertheless, only 70% of people living with HIV know their status and 53% receive antiretroviral treatment.[50] The burden of HIV is disproportionately high among girls in LMICs. Adolescent girls and young women aged 15–24 years are at high risk of HIV infection, accounting for 20% of new HIV infections among people aged 15–49 worldwide in 2015, despite being only 11% of the world population. The gender imbalance is greater in sub-Saharan Africa, where 25% of new infections among people of reproductive age were reported among girls and women in this age group.[51]

Gynaecology including cervical cancer screening

In 2012, 230,000 women in developing countries and 36,000 women in more developed countries died from cervical cancer. The difference in the burden of disease can be explained by the fact that coverage of cervical cancer screening in developing countries, where 83% of cervical cancer deaths worldwide occur, is on average 19%, compared to 63% in developed countries.[52] Moreover, there is large disparity in human papillomavirus (HPV) vaccination coverage by income level of countries and regions.[53]

Prenatal and post-natal care

Progress in increasing access to antenatal care has been slow over the past 25 years.[54] Only 52% of pregnant women received the recommended minimum of four visits in 2015. The disparity in post-natal care is prominent: a systematic review on post-natal care in LMICs showed that women with higher socioeconomic status, higher education and those living in urban areas were more likely to use post-natal care.[55]

Screening and referral for gender-based violence

It is estimated that more than one in three (35%) women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence in their lifetime.[56] The consequences are serious, ranging from injuries and disabilities to mental, sexual and/or reproductive health problems.[57] Moreover, the risk of violence is higher for people with disabilities, refugees and women in conflict settings.

Despite the high prevalence and serious consequences of sexual and gender-based violence, access to health services for survivors is far from universal. Due to stigma, shame and lack of or poor services, many women do not report violence or seek care. The *Global status report on violence prevention 2014* found that only half of 133 countries studied reported having violence-related services in place to protect and support survivors of violence.[58] The services are often fragmented and not integrated into the health system, leading to women having to navigate different services, pay large costs and experience long waits.[59] The WHO guidelines recommend that all healthcare professionals should be able to identify women experiencing violence and provide first-line supportive care including referral to other services, and that health systems need to coordinate the environment for healthcare providers to care for survivors.[60]

Financial protection and expenditure on sexual and reproductive health services and goods

Poor sexual and reproductive health services impose a substantial economic burden on health systems. Provision of adequate, accessible and comprehensive sexual and reproductive health services through financial protection such as national insurance schemes would substantially improve the health of women and children, and reduce the burden on health systems that are already overwhelmed in many countries.

The necessary investments in SRHR per capita are modest and are affordable for most low-income and middle-income countries. Less-developed countries will face funding gaps, however, and will continue to need external assistance.

Source: Guttmacher-*Lancet* Commission 2018[61]

A total of 283 studies were identified from the initial database search to be relevant for the review on financial protection, in terms of meeting sexual and reproductive health needs and expenditure on sexual and reproductive health services and goods. After screening titles and abstracts, the full texts of 36 studies were retrieved. After reviewing these texts, 13 studies plus three more studies from the reference lists were included for synthesis.

Insufficient financial commitments for sexual and reproductive health services and goods

A substantial proportion of spending on sexual and reproductive health services is currently paid by individuals due to a lack of financial protection and insufficient government and donor funding. For instance, contraceptive commodities are not covered by national insurance in many countries. In 2014, more than US$1.2 billion was spent on contraceptive supplies across 135 LMICs. The share of individuals who paid for their own contraceptive supplies was 58%, while all donor funding and domestic government expenditure on supplies were at 25% and 17% respectively.[62] Donor funding for sexual and reproductive health, especially sexual health, has fluctuated and cannot be expected to grow significantly beyond current levels. This means that an increased focus on mobilizing domestic resources in support of sexual and reproductive health services is essential.[63,64]

Limited financial protection for sexual and reproductive health services

Several governments have introduced financing mechanisms to alleviate poverty that results from seeking reproductive maternal health care. Mechanisms such as cash transfers, voucher systems and user fee waivers have generally increased the uptake of health services.[65,66,67] However, the key to protecting people from financial hardship is to ensure that most funds for a health system are prepaid through some type of insurance scheme or tax, and that services are purchased from these pooled funds in a way that limits the need for out-of-pocket payments.[68] Although national, social, community-based or public health insurance schemes or tax-funded health services as steps to UHC exist in many developing countries, the populations that are covered by such schemes are limited. People working in the informal sector and the most vulnerable and marginalized, such as young people and refugees, are left behind. Moreover, a study in Ghana has shown that even when insurance is available to women in the poorest income group, they were less likely to seek antenatal care than women from other income groups.[69]

Even when a financial protection scheme exists, the services covered by these schemes often do not include comprehensive sexual and

reproductive health services. A study of 20 LMICs in 2012–2015 found that no country studied had a community-based health insurance scheme with more than 100 members that had contraception included in the package.[70] Contraception is often left out while financial protection schemes often cover maternal and child healthcare services.

High out-of-pocket expenditure on reproductive health services

Substantial inequity in out-of-pocket expenditure also exists within countries. Over 38% of total expenditure on sexual and reproductive health services in Bihar – one of India's poorer states – was paid out-of-pocket, while in Karnataka – an economically more prosperous state – it was 22%.[71] A similar result was found in Kenya: 38% of total expenditure on sexual and reproductive health services derived from out-of-pocket expenditure. Among the total household out-of-pocket expenditure on general health services, families in Kenya spent 14% on sexual and reproductive health services.[72] The situation in Democratic Republic of Congo is even more challenging; households bear 68% of total expenditure on reproductive health, while the government contribution is only 0.2%.[73] Another study assessing household expenditure on sexual and reproductive health in India and Kenya found that there was a statistically significant difference in the proportions of spending on sexual and reproductive health services across income quintiles in both settings. In India, the poorest households spent two times, and in Kenya 10 times, more on seeking care than the least poor households.[74] Moreover, a literature review found that women systematically made higher out-of-pocket payments than men, partly due to the high financial costs related to delivery care and other reproductive health services.[75] Inequity in financial burdens is pervasive and prevents vulnerable and marginalized women from seeking health care.

The cost of unsafe abortion accounts for a substantial share of sexual and reproductive health spending for governments and households.[76] A study in the tertiary hospital in Lusaka, Zambia showed that around 39% of women had an unsafe abortion, leading to substantial economic costs in treatment and post-abortion care for women. It is estimated that the cost of unsafe abortion requiring treatment is 27% higher than the cost of a safe abortion. Adolescents and poor women were more likely to seek unsafe abortion.[77] A study in Ouagadougou, Burkina Faso showed that women who sought, mostly unsafe, abortion services were likely to be single and younger, with the cost as high as 15% of the gross domestic product per capita.[78] Provision of high-quality contraceptive services is one of the most cost-effective ways of preventing unsafe abortion and has substantial economic and health consequences. A study in four sub-Saharan African countries estimated that the cost of one year of modern contraceptive services and supplies was only 3–12% of the average cost of treating a post-abortion care patient.[79] Integrating access to contraceptive with safe abortion care further reduces unsafe abortion.

The pervasive inequity in financial burdens and limited financial protection among the poor, vulnerable and marginalized population is not acceptable. Investing in health for all saves lives and leads to sustainable development.

Sexual and reproductive rights to advance towards UHC

While UHC is a commitment underpinned by the fundamental human right to health, including sexual and reproductive health and rights, there is a large variation in how the commitment has been operationalized.[80] The progress-monitoring framework suggested by the key actors of UHC is narrowly focused, and the monitoring tracer indicators on health services coverage include only one reproductive health indicator – proportion of women satisfied with modern contraception. The right to health for all, which should reinforce UHC, has not been at the centre of discussions on UHC. It should also be noted that while the earlier section (see page 10) on access coverage showed the unacceptable inequity across regions and between high-income and low-income countries, even in high-income countries UHC is often inadequate and does not cover comprehensive sexual and reproductive health services to fulfil sexual and reproductive health and rights. The resources allocated often do not address the needs of vulnerable and marginalized populations.

Some population groups are subject to greater vulnerability and face greater difficulty accessing health services due to their sex, age, race, ethnicity, language, religion, disability, marital status, health status (including HIV status), sexual orientation, and economic status. Access for these groups to sexual and reproductive health services, supplies and

information, in particular, is affected by elevated stigma, discrimination, restrictive laws, policies, and social norms. People living with HIV, being an unmarried sexually active adolescent, a sex worker, a migrant, a transgender or intersex person, people who use drugs or engage in same-sex sexual behaviour face both marginalization and stigma.[81] This discriminatory environment prevents or even denies their access to sexual and reproductive health services, goods and information, causing an exacerbation of their health problems leading to further marginalization.

SRHR information and services should be accessible and affordable to all individuals who need them regardless of their age, marital status, socioeconomic status, race or ethnicity, sexual orientation, or gender identity.

Source: Guttmacher-*Lancet* Commission 2018[82]

A rights-based approach breaks this vicious cycle. The core aim of the approach is to realize the right to health and other health-related rights, including sexual and reproductive health and rights. It emphasizes the need to address the social determinants of health including discrimination and stigma as well as the provision of timely and adequate health services and information. A rights-based approach to health requires guarantees of: 1) the availability of functioning health care facilities, goods and services; 2) accessibility for every segment of a population without discrimination, physical obstacles, or economic barriers; 3) respectful medical ethics and acceptability to the population by taking into account the culture, interests and needs of different population groups, particularly the most marginalized; 4) a scientifically and medically appropriate quality of care; and 5) adherence to the four human rights principles of participation, equality, non-discrimination and accountability.[83] Evidence showed that a rights-based approach to health contributes to more equitable health outcomes.[84] A notable example of inclusion of a marginalized group is the provision of sexual health services and information to female sex workers. This type of intervention has been shown to lead to increased condom use and a reduction in HIV and STI transmission.[85] A rights-based approach builds resilience and sustainability into UHC and improves health outcomes by addressing the underlying determinants of health.

Selected examples of challenges to sexual and reproductive health and rights in relation to advancing UHC are discussed below.

Young people

The vulnerable and marginalized face considerable obstacles in accessing sexual and reproductive health services and realizing their sexual and reproductive health and rights.[86] Young and/or unmarried people often have limited access to quality information and services, and may require parental or third-party consent to access services. This lack of access is often exacerbated by the belief that young people cannot or should not make autonomous decisions about sex and sexuality. In some settings, young people's access to sexual and reproductive health services is denied in spite of the existence of supportive policies.[87,88] Some young people believe that healthcare providers may not respect confidentiality and be judgemental or unfriendly when they seek sexual and reproductive health services and commodities.[89]

When implemented well, the provision of evidence-based, accurate, unbiased, non-discriminatory CSE improves sexual and reproductive health knowledge, attitudes and behaviours, particularly programmes that adopt an empowerment approach and an emphasis on gender and rights.[90,91,92] The improved knowledge and behaviours contribute to the prevention of unintended pregnancy, unsafe abortion and transmission of HIV and other STIs.

In developing countries, 35% of young women aged 20–24 marry below the age of 18, and 12% below the age of 15. In South Asia, almost half of all young women marry before the age of 18. Young married women are at greater risk of sexual and gender-based violence.[93] Early and forced marriage violates girls' autonomy and affects their future educational attainment as well as their sexual and reproductive health.

People living with HIV

Although living with HIV is not itself indicative of sexual transmission of the virus, individuals are often discriminated against based on a presumption of sexual activity that is often considered socially unacceptable.[94] Widespread discrimination and stigma towards people living with HIV derived

from fear and misunderstanding is a significant barrier to their access to much-needed services.[95] Discrimination is associated with high levels of stress and depression as well as a lower likelihood of seeking HIV services.[96,97] This also applies to sexual and reproductive health services: a lack of confidentiality among healthcare workers is a key issue that affects women living with HIV seeking antenatal care.[98] A study in India found that women who were not using contraception following HIV diagnosis reported a lack of contraceptive counselling, low acceptability of contraception apart from condom and partner's involvement as reasons.[99] There are existing challenges to ensure people living with HIV fulfil rights to health, such as rights to safe and satisfying sex, rights to healthier lives (for example through access to cervical cancer screening), and right to have a child.[100]

People with disabilities

Approximately 15% of the world's population lives with some form of disability.[101] Despite the substantial numbers, the needs of people with disabilities are often neglected and overlooked. People with disabilities have often been denied sexual and reproductive health information and services, and the right to establish relationships and to make decisions over whether, when and with whom to have a family. Many people living with disabilities have experienced forced sterilizations or abortions.[102] It is estimated that people with disabilities are about three times more likely than non-disabled people to be victims of physical and sexual violence.[103] In 2008, the Convention on the Rights of Persons with Disabilities came into force and there has been progress in tackling the challenges people with disabilities face. Disability is referenced in several goals of the SDGs, yet support to respect, protect and fulfil the sexual and reproductive health and rights of those with disability is still largely neglected.

Survivors of gender-based violence

Attitudes, practices and knowledge among healthcare workers affect the quality of sexual and reproductive health services provided to people from diverse backgrounds. For example, a study of healthcare facilities in Afghanistan indicated major gaps in healthcare providers' knowledge of and attitude towards their role in helping survivors of gender-based violence.[104] It also found that staff in healthcare facilities in rural and urban areas were vulnerable to pressure from family members and local communities and had a seriously limited ability to respond to the needs of survivors.[105]

Nevertheless, awareness of and strategies to tackle gender-based violence have increased in some settings. Kenya's Ministry of Health has issued national guidelines for the medical management of rape and sexual violence that were explicitly shaped by the ICPD Plan of Action. For example, the guidelines emphasize the importance of the provision of emergency contraception, and indicate that a survivor should be informed of the legality of abortion should she become pregnant as a result of violence.

Female genital mutilation (FGM) is internationally recognized as a violation of human rights and a form of gender-based violence. An estimated 125 million women and girls have undergone FGM in 29 countries in the Middle East and Sub-Saharan Africa.[106] FGM is traumatic, painful and dangerous, and has severe immediate and long-term health consequences. A study by WHO shows that FGM has been associated with obstetric complications. The risk of caesarean section, post-partum haemorrhage, extended hospital stay and low birth weights were higher among women with FGM than those without FGM.[107,108,109] This indicates that FGM is not only a violation of human rights with significant health impacts on women and children, but also substantially increases the burden on health systems.

Conclusion

Ensuring the right to sexual and reproductive health yields high returns for sustainable development

Without ensuring universal access to sexual and reproductive health and rights, countries will not be successful in reducing inequalities, in stimulating and sustaining economic growth, or in ensuring environmental sustainability. Investment made in universal access to sexual and reproductive health and rights gives significant health, social and economic returns.

For example, there are currently 214 million women in LMICs who want to delay or prevent pregnancy but who are not using a modern method of contraception. Meeting their needs would prevent 67 million unintended pregnancies and approximately 25 million unsafe abortions every year.[110,111] It is also estimated that it would reduce maternal deaths by 76,000, newborn deaths from 2.9 million to 660,000, and HIV infections in newborns from 130,000 to 9,000 every year.[112] One of the key social benefits of family planning is the subsequent improvement in levels of education and gender equality. When individuals have control over sex and reproduction and are safe and healthy in their sexual and reproductive lives, they are better able to participate in education and the labour market, to care for themselves and their families, and have greater capacity to contribute to their communities and societies.[113]

Affordable sexual and reproductive health services will prevent people falling into poverty

The provision of affordable, accessible, acceptable, and quality sexual and reproductive health services covered by financial protection schemes reduces both financial hardship and health inequity. Furthermore, investing in sexual and reproductive health is one of the most cost-effective health interventions. For example, preventing unintended pregnancies and births by ensuring access to contraception will result in savings in obstetric, child health and other related services, together with savings which later impact on education. It is estimated that investing in contraceptive, maternal and newborn services results in annual net savings of US$6.9 billion compared with investing in maternal and newborn healthcare alone.[114]

Leaving no one behind

Equitable access to sexual and reproductive health and rights is still far from universal. UHC must be considered within a broader framework to address the underlying social determinants of health and make health systems not just functional but also free of barriers to even the most marginalized and vulnerable. Concerted efforts and concrete steps towards UHC must include access to information and power to make decisions to seek health care to realize the right to health for all.

Lack of social and financial protection in many countries means that sexual and reproductive health is largely paid for by individuals and households, with many unable to afford the services they need. Health policies and programmes need to implement effective measures, including the allocation of sufficient budget and financial resources. They also have to prioritise the needs of the most marginalized and vulnerable first to achieve greater equity, which is a principle of the SDGs and UHC.[115]

An approach that fails to address barriers to sexual and reproductive health and rights, including stigma, discrimination and gender inequality, or to make sexual and reproductive health and rights information and services available, accessible, affordable, acceptable and of good quality, does not constitute the full implementation of UHC. Ensuring sexual and reproductive health information and services as part of a core package of essential health services that is universally available and affordable leads to progress towards UHC, leaving no one behind.

Everyone has a right to make decisions that govern their bodies, free of stigma, discrimination, and coercion. These decisions include those related to sexuality, reproduction, and the use of sexual and reproductive health services. Countries should incorporate the essential services […] into universal health coverage, paying special attention to the poorest and most vulnerable people. Essential services should include:

- **accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education**
- **information, counselling, and care related to sexual function and satisfaction**
- **prevention, detection, and management of sexual and gender-based violence and coercion**
- **a choice of safe and effective contraceptive methods**
- **safe and effective antenatal, childbirth, and post-natal care**
- **safe and effective abortion services and care**
- **prevention, management, and treatment of infertility**
- **prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections, and**
- **prevention, detection, and treatment of reproductive cancers.**

Source: Guttmacher-*Lancet* Commission 2018[116]

IPPF's contribution to universal health coverage

IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights* with a worldwide movement of national organizations (called Member Associations) working with and for communities and individuals in 152 countries. By promoting universal access to sexual and reproductive health services that are stigma-free, good quality and affordable for everyone, IPPF contributes to universal health coverage.

At the heart of IPPF's service delivery model are the people it serves, especially the poor and vulnerable†

Some populations are more vulnerable to sexual and reproductive ill health and lack access to quality health services, supplies and information due to certain characteristics including age, gender, gender identity, ethnicity, sexual orientation, HIV status, education, disability, migrant status, and the stability of their environment, or they are denied access because of cultural practices or due to restrictive laws and policies. IPPF addresses these obstacles by challenging stigma and discrimination, using disaggregated data to focus attention on population groups that are most under-served, and advocates for policies which ensure that the marginalized have access to the services and information they need. These interventions have enabled IPPF to reach 59.1 million poor and vulnerable people, including 3.1 million needing humanitarian assistance, and provide 88.6 million sexual and reproductive health services to young people in 2017.

LEAVING NO ONE BEHIND: IPPF'S GLOBAL REACH§

208.6 million
sexual and reproductive health services delivered globally and
177.9 million (85%)
in countries having low or medium levels of human development

73.6 million
service users including
59.1 million (80%)
poor and vulnerable people

40,131
service delivery points, including
24,533 (61%)
IPPF-owned service delivery points

130
policy or legislative changes in support or defence of sexual and reproductive health in
66
countries

* The right to have control over and decide freely and responsibly on matters related to sexuality, sexual health, and reproductive health free of coercion, discrimination and violence. 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.

† IPPF considers poor and vulnerable people to include young people, people who use drugs, sex workers, people living with HIV, displaced populations, sexual and gender diverse groups, survivors of gender-based violence and people with disability.

§ IPPF 2018 *Annual Performance Report 2017*

IPPF advocates for affordable sexual and reproductive health services

Understanding the financial burden that out-of-pocket healthcare expenditure puts upon the poor and vulnerable, IPPF Member Associations practise a 'no-refusal policy' to ensure every client receives the services they need regardless of their ability to pay. Championing universal access to sexual and reproductive health services, IPPF has advocated for policy changes that ensure affordable health services and commodities globally and nationally. In 2017, IPPF contributed to 146 changes in policy or legislation in support or defence of sexual and reproductive health and rights: two policy changes at global level, 14 changes at regional level and 130 at country level. For example, Centro de Investigación, Educación y Servicios was successful in getting the Ministry of Education of Bolivia to create new regulations to allow young women to continue their education during pregnancy and after childbirth.

IPPF's contribution to strengthening health systems is critical to achieving universal access to sexual and reproductive health

A 40,131-strong service delivery network consisting of static clinics, mobile clinics, community-based distributors and associated clinics‡ enables access to sexual and reproductive health services and essential medicines and commodities.

Trained and skilled healthcare workers, including medical professionals, peer educators, community health workers and volunteers, are key to delivering stigma-free sexual and reproductive health services. Recognizing the quality of IPPF's service delivery, Member Associations are contracted to build the capacity of government healthcare workers. Furthermore, IPPF's Member Associations are working to increase access to quality and affordable services for low-income populations by social franchising programme. For example, the Family Guidance Association of Ethiopia (FGAE), IPPF's Member Association in Ethiopia, increased social franchise clinics from 40 to 326 between 2014 and 2017. During the same period, FGAE increased the number of contraceptive services provided more than tenfold.

IPPF's strong distribution and supply chain resulted in 11,097 public and private partners receiving contraceptive commodities from IPPF in 2017, so that women and girls had uninterrupted access to a comprehensive method of their choice.

Without IPPF, access to sexual and reproductive health services for many people would be severely limited due to a lack of political will, expertise or institutional capacity. IPPF's strong community-based health service delivery, tackling the social determinants of health and upholding the sexual and reproductive rights of the marginalized and under-served, will contribute to universal health coverage.

‡ IPPF categorizes an associated clinic to be a clinic that belongs to private individuals, organizations or the public sector, which provides sexual and reproductive health services by trained doctors, clinicians and or counsellors. IPPF Member Associations have an agreement to provide significant technical support, monitoring, quality of care and oversight, and in some cases provide contraceptives and other sexual and reproductive health commodities to the associated clinic. An associated clinic is not managed by the IPPF Member Association and services are provided by the associated clinic staff.

AFGHANISTAN

Addressing gender-based violence to reach universal health coverage in Afghanistan

Afghanistan is a low-income country ranked 169th on the human development index[117] and has a fragile health system. The main challenges of rebuilding Afghanistan's healthcare system include lack of security, lack of infrastructure, economic hardship, poor coordination among government and healthcare providers, difficult access to healthcare facilities, unsuitable hospital conditions, and few trained healthcare workers, especially women.[118]

Access to the limited healthcare services is further worsened by gender, social and economic disparities. Achieving universal health coverage will be impossible if these inequalities are not addressed during the country's reconstruction process.

Universal health coverage in Afghanistan

The Basic Package of Health Services and the Essential Package of Hospital Services in Afghanistan represent the approaches taken by the government to promote free universal coverage across the entire country since 2003,[119] emphasising priority access to the groups in greatest need, especially women, children, people with disabilities and those living in extreme poverty.[120] However, neither document includes a comprehensive approach to address the needs of survivors of gender-based violence. Studies suggest that 87% of Afghan women experience at least one form of physical, sexual or psychological violence and 62% experience multiple forms.[121] Furthermore, healthcare facilities, which are often the only hope for survivors of gender-based violence to seek support, do not have the necessary infrastructure or trained staff to provide a comprehensive service.[122]

KEY HEALTH INDICATORS FOR AFGHANISTAN	
Total population (2017) †	**35.5 million**
Gross national income per capita, PPP (2016, Intl $)*	**1.88**
Life expectancy at birth m/f (years)	**59/62**
Under 5 mortality rate (per 1,000 live births)	**55**
Total fertility rate	**5.3**
Percentage of unmet need for family planning	**25%**
Percentage of births delivered by a skilled provider	**50.5%**

Sources: Afghanistan Demographic and Health Survey 2015, unless noted otherwise. †United Nations, Department of Economic and Social Affairs, Population Division (2017). World Population Prospects: The 2017 Revision, custom data acquired by website https://esa.un.org/unpd/wpp/. *World Bank Open Data, https://data.worldbank.org/

Since 2005, the deterioration of the security situation has had a detrimental effect on the life of Afghans and the development effort, including access to and coverage of healthcare.[123] In addition, an unhealthily large proportion of healthcare expenditure is sourced privately as out-of-pocket payments.

HEALTH EXPENDITURE RATIOS	2005	2010	2014
Government expenditure on health as a % of total government expenditure	**10**	**31**	**36**
Total expenditure on health as a % of gross domestic product	**8**	**9**	**8**
Government expenditure on health as a % of total health expenditure	**6**	**14**	**12**
External resources for health as a % of total health expenditure	**13**	**26**	**23**
Out-of-pocket payments as a % of total health expenditure	**90**	**69**	**64**

Source: WHO Global Health Observatory data http://apps.who.int/gho/data/node.main.75

According to the government's 2014 National Health Accounts (NHA), 17.1% of government health expenditure is allocated to reproductive health, which includes gender-based violence. The NHA report goes on to recommend "the central government may need to consider increasing investments in reproductive health."

Gender-based violence in Afghanistan

Gender-based violence is a pervasive problem in Afghanistan. It stems from complex inequalities and cultural practices which, when aligned with poverty and lack of awareness, subordinate women to men and prevent them from acting on or receiving support.[124]

Recognizing the critical need to address the issue of gender-based violence, the government passed a presidential decree in 2009 to eliminate violence against women. This criminalizes 22 acts of violence against women including child marriage, forcing or prohibiting marriage, rape, beating and denying access to health services. The law also promotes

public awareness and training on violence against women and the prosecution of perpetrators.

Progress is being made to address the health needs of survivors of gender-based violence. WHO is training 6,500 healthcare providers in all provinces of Afghanistan on comprehensive case management of gender-based violence including physical, sexual and psychological violence. The introduction of a Family Protection Centre within existing government health facilities offers integrated services including psychosocial, medical and legal support and referral services into the health sector, and acts as a one-stop assistance centre.

Good practices to address gender-based violence and achieve universal health coverage*

The **Afghan Family Guidance Association (AFGA)**, an IPPF Member Association, is a leading civil society organization addressing gender-based violence in the country. With a mandate to promote sexual and reproductive health and rights, AFGA reaches out to communities, religious leaders and key stakeholders as well as government organizations to influence their knowledge, attitudes and practices towards gender-based violence. Examples of best practice include:

Quality, integrated and stigma-free sexual and reproductive health services enable AFGA's Family Welfare Centres to address the needs of survivors of gender-based violence. Most AFGA clients are women and young people, especially those from vulnerable, poor and marginalized communities. Health workers from the centres have been trained on confidentiality, screening, treatment and risk assessment for gender-based violence to ensure clients receive quality, stigma-free services. Furthermore, the centres' counsellors have received specialised training to respond the psychosocial needs of survivors of gender-based violence, including developing safety plans and coping strategies.

AFGA promotes an extensive referral pathway to meet the different needs of survivors of gender-based violence. AFGA partners with key government agencies and non-governmental organizations to enable the provision of specialized services to survivors and to expand the referral network. AFGA community workers provide follow-up support to any clients referred to other services to ensure they access the health- and non-health-related services they need. AFGA has also developed standard operating practices to facilitate joint action by all actors in responding to gender-based violence, and has established a multi-sectorial working group at community level.

Sensitizing key stakeholders on gender inequality to create an enabling environment. AFGA has advocated for the Ministry of Haj & Islamic Affairs to play a leading role in changing community perceptions, attitudes and practice on gender equality and gender-based violence. Written by senior religious leaders and coordinated by AFGA, a book on 'Islam and the Family', which promotes positive family norms based on Islam's teachings, is being printed by the Ministry to be used during Friday mosque discussions. AFGA also conducts sessions with community leaders, police officers, schoolteachers and legal practitioners on what they can do to prevent gender-based violence and support survivors. AFGA has so far conducted 47 sessions, sensitizing 1,397 stakeholders.

EXPERIENCE OF PHYSICAL VIOLENCE AMONG EVER-MARRIED WOMEN IN AFGHANISTAN

Background characteristic	% who have experienced physical violence since 15 years of age
Age of women	
15–19	**32.9**
20–24	**46.1**
25–29	**53.6**
30–39	**55.9**
40–49	**60.0**
Marital status of women	
Married	**52.8**
Divorced/separated/widowed	**58.9**
Residence of women	
Urban	**43.1**
Rural	**55.7**

Source: Afghanistan Demographic and Health Survey 2015

* These good practices are part of the learning from an IPPF Japan Trust Fund project implemented by AFGA in 2012–2014

CAMBODIA

Reaching under-served populations for universal access to sexual and reproductive health in Cambodia

Cambodia is a middle-income country with a population of 16 million, 60% of which is under 30 years of age.[125] Sustained economic growth driven by garment exports and tourism[126] has contributed to a significant decline in the proportion of population below the poverty line,* from 47.8% in 2007 to 18.9% in 2012.[127] Cambodia has also made impressive progress in reducing maternal and child mortality and HIV prevalence rates. However, more work is required to reach the health targets set out in the Sustainable Development Goals.

Universal health coverage in Cambodia

Cambodia is committed to improving access to health services and universal health coverage (UHC) is explicitly mentioned in Cambodia's *Health Strategic Plan 2016–2020*, which highlights the necessity of reaching vulnerable population groups and people living in poor performing geographical areas to achieve UHC. One of the main barriers to this is a weak public health system and underused public health services, due to their poor quality. The private healthcare sector (including non-profit clinics) accounts for two-thirds of healthcare services provided.

Health expenditure per capita accounts for 7% of GDP, which, although the highest in the region, still falls below what is required. Out-of-pocket payments account for 60% of total health expenditure.[128] To address such high out-of-pocket expenditure and inequity in coverage of healthcare, Cambodia has expanded its social health insurance schemes.[129] The National Social Security Fund includes approximately 200,000 civil servants, veterans and retirees and over 1 million formal private sector employees. The poor and vulnerable (including people with disabilities) are insured through different health schemes. This includes the Health Equity Fund covering around 3 million people, voucher schemes for free reproductive and child health services covering approximately 1 million women and children, and community-based and private health insurance schemes based on voluntary and private contributions covering approximately 1 million people.

POPULATION HEALTH AND HEALTH SERVICE INDICATORS	
Infant mortality rate (per 1,000 live births)	**28**
Under-five mortality rate (per 1,000 live births)	**35**
Maternal mortality ratio (per 100,000 live births)	**170**
Total fertility rate	**2.7**
Contraceptive prevalence (use of a modern contraceptive method)	**38.8**
% unmet demand for contraceptive methods among currently married women	**12**
% of women aged 15–49 having had one or more abortions in the past 5 years	**12**
% of births attended by a skilled provider	**89**
% of people aged 15–24 who have comprehensive knowledge about HIV	
Male	**38**
Female	**46**
% of people aged 15–24 self-reporting symptoms of STIs in the past year	
Male	**0.6**
Female	**4.4**

Sources: Cambodia Demographic and Health Survey 2014

Access to sexually transmitted infection prevention and treatment services for vulnerable populations

The **Reproductive Health Association of Cambodia (RHAC)**, IPPF's Member Association in Cambodia, is a major provider of sexual and reproductive health services. RHAC contributes to Cambodia's efforts to realize UHC by 2030 by reaching vulnerable and marginalized populations such as female sex workers, entertainment workers, men who have sex with men, transgender and migrant populations with essential and rights-based sexual and reproductive health services. These populations face a high risk of sexually transmitted infections (STIs), unintended pregnancies and a host of reproductive health problems.[130]

The limited published materials on STIs in Cambodia indicate the prevalence of STIs to be low among the general population. STI services are included in government insurance schemes, which contribute to improved equity in reproductive health.[131] Access to STI services is available countrywide at 51 STI clinics run by the National Center for HIV/AIDS and STIs, 18 clinics run by non-governmental organizations (NGOs) such as RHAC and 225 health centres

* The national poverty line defined as an absolute poverty line of 2,200 calories per person per day

offering STI services based on a syndromic approach.[132] As a major provider of STI services, RHAC treated 59% of all clients seeking treatment for STIs in 2015. Between 2012 and 2016, RHAC received over 1 million clients, of which 15% were garment workers.

The garment industry is one of the main economic contributors in Cambodia, employing over 600,000 workers. Most are young, migrant, female and unmarried workers of reproductive age.[133] In studies from 2012–2015, over 56% of garment workers reported having received treatment for an STI, but only 54% reported using condoms with a partner and only a small proportion were able to identify signs and symptoms of STIs.[134,135]

RHAC works with 82 garment factories in four municipalities and provinces, covering 130,000 garment workers. As part of its pioneering workplace health programmes, RHAC raises awareness on sexual and reproductive health and rights issues, distributes condoms and works with factory managers and administrators to include sexual and reproductive health into workplace health policies.

Good practices in delivering sexual and reproductive health services to vulnerable garment workers*

RHAC provides high quality, rights-based sexual and reproductive health services. RHAC is guided by IPPF's Quality of Care Charter and provides quality, confidential, stigma-free services that are highly valued by clients. RHAC health service providers are trained to take a client-centred approach to their work and services are routinely monitored through annual quality of care assessments and client satisfaction forms.

"Sometimes people don't know about medicine, and some places aren't safe. At RHAC, we know we will be safe… they know my needs as a woman. Most importantly I am assured of the high level of confidentiality they practise with client information." **A 27-year-old garment factory worker in Phnom Penh**

Using mobile phone technology and social media to support behaviour change. RHAC shares sexual and reproductive health and rights information through telephone hotlines and lines with pre-recorded information on sexual and reproductive health topics. This method gives clients the freedom to access information at their convenience and guarantees confidentiality, empowering clients to make choices and decisions about their sexual and reproductive health and well-being. In 2016, a total of 10,602 calls to RHAC's hotline and pre-recorded messaging system were received.

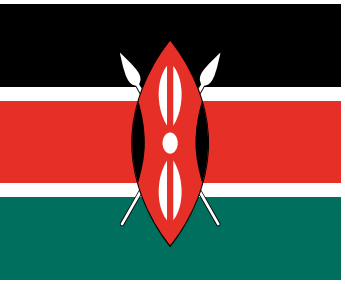
RHAC works in partnership with management teams in factories and Cambodia's Ministry of Labour and Vocational Training, sensitizing them on the importance of addressing workers' sexual and reproductive health needs and creating an enabling environment for factory workers to access information and services. As a result, management teams that RHAC works with are now introducing sexual and reproductive health services into their health policies.

"I support RHAC's strategies on family planning and sexual and reproductive health because factory workers are mostly at reproductive age, and they should adopt family planning. Therefore, if RHAC is working to address this problem, factory workers will have children according to their plan and [their] ideal family size." **HE Huy Han Song, Secretary of State of the Ministry of Labour and Vocational Training**

"RHAC has a long experience providing reproductive health services, and it has gained trust from factory workers as a place for women's health, with good quality and friendly services. We support RHAC's work for they benefit our workers' health." **Compliance Chief, Reliable factory**

* These good practices are based on learning from an IPPF Japan Trust Fund project implemented by RHAC in 2013–2015

KENYA



FAMILY HEALTH OPTIONS KENYA

Investing in adolescent and youth-friendly sexual and reproductive health and rights to achieve universal health coverage in Kenya

Kenya has a rapidly growing population, with the majority (52%) of its 49.6 million people below 20 years of age.[136] This puts great demands on provision of health services, education, water and sanitation, housing and employment.

When young people have universal access to education and healthcare, including sexual and reproductive health services, it also provides opportunities for a country's development. Adolescent and youth-friendly sexual and reproductive health services are important to ensure young people have access to information and healthcare services in an enabling environment.

Universal health coverage in Kenya

The Kenyan government has committed to achieve UHC by 2030.[137,138] In 2007 it launched a long-term development plan, *Vision 2030*, aiming to transform the country into an industrialised middle-income country and emphasising a high quality affordable healthcare system.[139,140,141] The *Health Financing Strategy* of 2010 reiterated these commitments towards UHC. It emphasises social health protection for Kenyans through introducing social health insurance and tax financing for vulnerable populations.[142] The National Hospital Insurance Fund is currently the main provider of health insurance, primarily funded through general revenue and member contributions. It provides formal-sector employees with compulsory insurance and informal-sector workers with voluntary insurance and covers 19.6% of the Kenyan population.[143]

SNAPSHOT OF ADOLESCENT (15–19 YEARS) SEXUAL AND REPRODUCTIVE HEALTH IN KENYA		
Background characteristic	Male %	Female %
Unmet need for contraception		23
Girls aged 15–19 who have given birth		15
Married adolescent girls using modern contraceptive methods		37
Adolescent mothers under 20 years who received 4 or more ANC visits		49
Adolescent mothers who gave birth without the assistance of a trained health professional		40
Female genital mutilation/cutting in girls aged 15–19		11
Adolescents who received HIV test in 2014	53	41
Adolescent girls and adolescent boys who received HIV test results	41	53

Source: Kenya Demographic and Health Survey, 2014

However, inequality in overall health insurance coverage across Kenya is still high.[144] One of the biggest challenges for the Kenyan health system is the inadequate coverage of financial protection for the informal sector, especially poor populations. The wealthy and those living in urban centres are more likely to have insurance than the poor and those in rural areas. Out-of-pocket payments for health care in Kenya are also high (26.6% in 2012/13).[145] The proportion of the population incurring catastrophic health expenditure was 6.2% in 2013. Kenya's health financing envelope is progressing gradually, but falls short of the 2001 Abuja Declaration in which African nations made a commitment to allocate 15% of their national budgets to the health sector.

Sexual and reproductive health coverage for young people in Kenya

Sexual and reproductive health and rights has been recognized as a priority within the Kenya Essential Package of Health, as outlined in Kenya's *National Health Sector Strategic and Investment Plan II 2013–2017*. The government has committed to providing youth-specific services including reproductive health counselling, contraceptives and HIV-related services through the establishment of youth-friendly sexual and reproductive health services within existing health facilities.

However, due to insufficient funding for youth-friendly services, access and coverage is variable in scope across the country and unequal between urban and rural areas. The sexual and reproductive health needs of more vulnerable groups within the youth population, such as lesbian, gay, bisexual and transgender youth, are also not adequately met in most health facilities. There is also a need to address the cultural, religious and traditional value systems that prevent healthcare workers from providing good quality and comprehensive sexual and reproductive health services to young people. **Family Health Options Kenya (FHOK)**, IPPF's Member Association in Kenya,

is working at the community level to provide youth-friendly services and comprehensive sexuality education for young people in and out of school.

Good practices in providing youth-friendly sexual and reproductive health services and ensuring universal health coverage for adolescents and young people*

Established in 1987, the **Nairobi Youth Centre** is one of FHOK's oldest youth centres. Its core objective is to provide reproductive health information to young people aged 10–24 and offer services including diagnosis and treatment of HIV and STIs, counselling on and management of sexual and reproductive health related issues, pregnancy tests and family planning services. Through running the centre, FHOK has learned that young people are more likely to take up sexual and reproductive health services at locations where there are opportunities to also address other social and health-related needs. Therefore the centre also provides treatment of minor ailments and training in vocational and life skills (such as hairdressing, computer skills, self-reliance) alongside sexual and reproductive health services.

The **Friends of Youth** model is a community-based adult mentoring model FHOK has implemented in central parts of Kenya and slums around Nairobi, that involves training a cadre of trusted adults (younger parents) in the community to discuss issues around sexuality with young people and provide youth-friendly sexual and reproductive health services. These mentors target young people in the community, including vulnerable groups such as men who have sex with men, vulnerable girls, domestic workers and sex workers, with information on sexual and reproductive health and rights. They refer young people to designated private health facilities for HIV and sexual and reproductive health services that are subsidised by FHOK. In schools, the mentors facilitate the formation of school health clubs and train peer educators. As part of the model, private practitioners are identified and trained by FHOK on providing youth-friendly sexual and reproductive health services.

The **Young Men as Equal Partners project** in Homa Bay county aimed to improve women's access to sexual and reproductive health services through the transformation of attitudes towards sexual and reproductive health in young men and boys. FHOK sensitized key decision-makers at community level (village elders both male and female, church leaders, chiefs) on the specific sexual and reproductive health needs of young people to ensure buy-in from the community for the project. Male 'champions' from the community, trained by FHOK, targeted young men (aged 20–24) at locations where they regularly congregated, facilitating the formation of health clubs and encouraging discussions on attitudes towards gender and sexual and reproductive health. Young men were also encouraged to accompany their partners in accessing sexual and reproductive health services. Young men who accessed sexual and reproductive health services or supported their partners to do so were formally recognized within community gatherings. These activities were complemented by education sessions in secondary schools, targeting young people aged 10–19. At the end of the project, the out-of-school health clubs became community-based organizations which continued to provide services to young people. In addition, local government within the project areas incorporated the project activities into their annual district plans.

"By connecting young people to accessible adults in their communities we have seen an increase in discussions about sexual health issues between young people and adults, improved knowledge of STIs among young people, and more young people considering when to have sex for the first time. These are just a few of the improvements FHOK has seen."
Programme Manager, FHOK

* Some of these good practices are derived from learning from IPPF Japan Trust Fund projects implemented by FHOK in 2004–2005 and 2012–2014

SUDAN

Sexual and reproductive health services for internally displaced populations in Sudan

Sudan is the 10th most populated country in Africa with a total population of 40.5 million people and a total fertility rate of 4.75.[146] According to the Ministry of Social Welfare, 46.5% of the population in Sudan live below the poverty line.

Sudan's gross domestic product (GDP) growth has deteriorated since 2015 due to the separation of South Sudan, ongoing conflict, sanctions, trade embargoes and falling oil prices. These factors have affected health financing, adding pressure to an already fragile health sector.[147]

Universal health coverage in Sudan

Around 36% of primary healthcare (PHC) facilities across Sudan are not fully functional, either due to staff shortages or poor physical infrastructure. Only 24% of the functional health facilities offer all main service components of the PHC package (42% in Darfur due to NGO support).[148] To ensure more people have access to essential quality health services, the government of Sudan is expanding its health care coverage programme. This programme is expected to address the disparities within the different states, reach people in remote areas with essential healthcare services[149] and expand coverage of PHC services from 86% to 100%. It also aims to boost the availability of basic packages of PHC services from 24% to 100%, ensure everyone has access to health insurance and increase the availability of free medicines.[150]

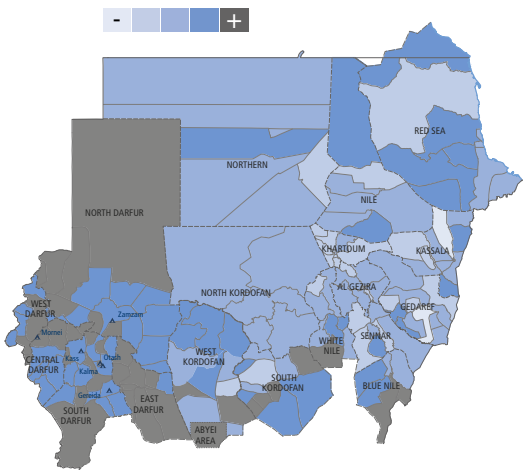
To provide financial protection for the Sudanese population when accessing health care, the government expanded its National Health Insurance Fund (NHIF) to include university students, orphans, pensioners and poor families.[151] The NHIF is financed from government tax, individual participation fees and contributions from the Zakat Chamber:* national coverage is estimated to be 43.8%.[152] However, a lack of qualified medical staff and a high proportion of patients to health workers continues to be a challenge to expanding NHIF. The NHIF package includes all medical consultations, admissions, diagnostic procedures and therapeutics including surgical operations; drug costs are covered up to a maximum of 75%. Sexual and reproductive health services are included in the package, with the same limitations on drug costs.

* The Zakat Chamber is a government body that makes annual deductions from Muslim citizens' basic income and redistributes this income to the poor through support for the NHIF and other distribution mechanisms

Reaching internally displaced persons in Sudan

The Sudanese government's efforts to expand health coverage need to ensure vulnerable and marginalized populations are not left behind. An estimated 2.3 million internally displaced persons (IDPs) are in need of humanitarian assistance in Sudan;[153] a significant proportion of these include young people and women of reproductive age. The map below indicates severity of health needs according to different states, which correlates with the regions home to large numbers of people needing humanitarian assistance.

SEVERITY OF HEALTH NEEDS MAP



Source: UN OCHA 2017[154]

Since 2015, Sudan's health policies have been revised to reflect the needs of IDPs: changes have been made by the NHIF and the Humanitarian Aid Commission to include IDPs under the health insurance umbrella through the Zakat Chamber. Furthermore, Sudan's *National Health Policy 2017–2030* proposes to address the healthcare needs, including the sexual and reproductive health needs, of IDPs as a special category with significant needs. The policy identifies gender-based violence, gynaecology, obstetrics and paediatrics as priority areas.

State-level reproductive health departments have started to refurbish clinics and build the capacity of health staff at primary and secondary levels to provide emergency obstetric and neonatal care, infection prevention and control, safe motherhood and family planning services to ensure the provision of quality services needed by IDPs.

Good practices in delivering sexual and reproductive health services to vulnerable internally displaced populations*

IPPF's Member Association in Sudan, the **Sudan Family Planning Association (SFPA)**, has been addressing the sexual and reproductive health needs of IDPs in eight states, through nine mobile and five satellite clinics. By ensuring no one who needs sexual and reproductive health services is left behind, SFPA contributes to Sudan's health care coverage programme so the country achieves UHC by 2030. Some of SFPA's promising practices in serving the needs of IDPs are:

Quality, integrated services through a client-centred approach. SFPA provides sexual and reproductive health services including family planning; HIV and STI prevention and treatment; antenatal and post-natal care; counselling and infertility treatment. These services are provided by well-trained healthcare workers who follow protocols and guidelines to ensure a high standard of care. SFPA also trains government health staff on providing stigma-free services to IDPs.

Providing comprehensive sexuality education (CSE) to young IDPs. A large proportion of IDPs in Sudan are under the age of 18. SFPA has identified them as an important group to reach through sexual and reproductive health information and youth-friendly services. SFPA selects peers from adolescents and young people within the IDP camps and trains them to conduct educational sessions on CSE with their peers. SFPA focuses specifically on sexuality education as well as sexual and gender-based violence when addressing the needs of adolescent IDPs. The young peers also make visits to homes in the camps and refer young people in need of services to SFPA clinics.

Providing a continuum of care for IDPs through partnerships. SFPA works with a range of partners so that IDPs have access to a continuum of care beyond sexual and reproductive health services. For example, SFPA provides sexual and gender-based violence screening and counselling services to IDPs and refers those needing further support to hospitals, social protection and legal services as required. To enable effective referrals, SFPA has partnerships with federal and state health authorities, lawyers' groups, UN organizations, the General Federation of Sudanese Women, the Women Workers' League and other community-based organizations for women.

SFPA counsellors provide support to IDPs beyond providing immediate sexual and reproductive health services; they also help IDPs access Muslim zakat charities and register for health insurance cards. IDPs living with HIV are linked with networks of people living with HIV to receive psychosocial support.

SEXUAL AND REPRODUCTIVE HEALTH SERVICES PROVIDED TO IDPs IN NORTH AND SOUTH DARFUR			
Services provided to IDPs through mobile and satellite clinics	2015	2016	Up to Sept 2017
Total sexual and reproductive health services provided to IDPs	32,416	53,486	59,794
Sexual and reproductive health services provided to women	19,765	47,561	39,857
Sexual and reproductive health services provided to young people	16,308	26,763	25,341

Source: Service statistics, SFPA

"When we identify a gap in service provision for IDPs, we try to address it. For example, SFPA established a satellite clinic at Abu Shouk camp in North Darfur as the nearest hospital is about 10KM away from the camp. Pregnant women and mothers with little children found it difficult to access the hospital and now they are delighted to receive health services through our satellite clinic." **Executive Director, SFPA**

* These good practices are part of the learning from an IPPF Japan Trust Fund project implemented by SFPA in 2014–2016

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ABOUT THE IPPF JAPAN TRUST FUND

Set up in 2000, the IPPF Japan Trust Fund represents the visionary partnership between the Government of Japan and IPPF to address the global health challenges posed by HIV and sexual and reproductive ill health. Its aims are to:

- contribute towards universal access to integrated HIV and sexual and reproductive health services, in particular for the vulnerable and marginalized populations
- raise public awareness about the partnership between the Government of Japan and IPPF to respond to current global health challenges, through providing comprehensive sexual and reproductive health services and realising human security.

Since its establishment, the Japan Trust Fund has enabled IPPF to integrate HIV services into sexual and reproductive health and rights programmes across Africa and Asia – through capacity building and dedicated projects. Equally, it ensures that, as a donor, the Government of Japan's response to HIV and sexual and reproductive health and rights remains people centred and contributes to human security.

Between January 2000 and November 2018, 57 IPPF Member Associations in Africa, Asia and the Middle East have received support from the Fund to implement a total of 143 projects. The breadth and scope of the Fund is evident in its spread and the array of projects – from increasing access to maternal and child health services in rural Pakistan to working with a Japanese company for quality of care improvement in Uganda, and from reaching out to internally displaced people in Darfur to preventing HIV among factory workers in Samoa.

IPPF would like to express its sincere appreciation to the Government of Japan for its continued support of IPPF and its Member Associations through this initiative.

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4 Newhams Row
London SE1 3UZ
United Kingdom

tel: +44 20 7939 8200
fax: +44 20 7939 8300
email: info@ippf.org
www.ippf.org

UK Registered Charity No. 229476