CHAPTER IV: How can health professionals address poverty and gender in sexual and reproductive health programmes?

The burden of sexual and reproductive ill-health appears to be concentrated in developing countries in the Region. Within these countries, poor communities seem to suffer a disproportionate burden. For example, women from poor households are more likely than their better-off counterparts to die during pregnancy and childbirth. In addition, men and women experience sexual and reproductive health differently, with women of all ages appearing to be particularly affected by sexual and reproductive ill-health.

Despite this, the technical solutions necessary to improve the sexual and reproductive health of the poor exist: effective methods of contraception have been known for decades and simple technologies to make pregnancy safer are available; the ability to enhance safe-sex practices has been documented; and many STIs are treatable. Overall, we have the information and means to expand the coverage of quality sexual and reproductive health services. What is needed are ways to ensure that these solutions reach those who are most in need.

The sections below discuss strategies to tackle the burden of sexual and reproductive health among the poor in the Region and suggest approaches to respond to the different sexual and reproductive health needs of men and women.

Policy level

International policies

At the international level, human rights have become a central framework for conceptualizing sexual and reproductive health. As recognized at the ICPD, men and women have the right to make voluntary, informed decisions concerning their sexual and reproductive health. The ability to make such decisions, however, depends on the realization of a range of entitlements, such as the right to appropriate reproductive health services and to adequate information. This rights-based approach to sexual and reproductive health references a range of human rights treaties, as discussed in section 3, and has been reiterated in the outcome documents of a number of international conferences.

United Nations Member States committed themselves to realizing a series of time-bound and measurable targets—the Millennium Development Goals—by signing the Millennium Declaration in 2000. The MDGs reflect a multidimensional understanding of poverty. As such, progress towards any goal contributes to the achievement of all of them. Health issues feature prominently in the MDGs (three goals, eight targets, 18 indicators). Sexual and reproductive health is not articulated in a single goal, but rather spread unevenly over four goals and

numerous targets and indicators (see Box 10). Some fear that compartmentalizing sexual and reproductive health across these three goals might divert attention from the more comprehensive notion of sexual and reproductive health adopted at the ICPD. A growing body of evidence demonstrates the importance of sexual and reproductive health for all of the MDGs, with particular reference to Goals 3, 4, 5 and 6. In response, the international community has acknowledged the close links between the ICPD PoA and realization of the MDGs.

In many ways, the MDGs echo the goals and targets put forward in the ICPD PoA: reducing maternal mortality, reducing child mortality, ensuring universal access to primary education and ensuring access to secondary education. The twenty-first special session of the United Nations General Assembly, held to review and appraise the implementation of the ICPD PoA in 1999 (ICPD +5), outlined additional benchmarks, including a goal for preventing HIV/AIDS, which is also included among the MDGs. At the World Summit held in September 2005, world leaders affirmed the importance of sexual and reproductive health for the achievement of all the MDGs by committing themselves to:

…achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed

Box 10: International goals and targets for sexual and reproductive health

Millennium Development Goals

Goal 3. Promote gender equality and empower women

Target 4. Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

Indicators:

9. Ratio of girls to boys in primary, secondary and tertiary education
10. Ratio of literate women to men, 15–24 years old
11. Share of women in wage employment in the non-agricultural sector
12. Proportion of seats held by women in national parliament

Goal 4. Reduce child mortality

Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Indicators:

13. Under-five mortality rate
14. Infant mortality rate
15. Proportion of one-year-old children immunized against measles

Goal 5. Improve maternal health

Target 6. Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Indicators:

16. Maternal mortality ratio
17. Proportion of births attended by skilled health personnel

Goal 6. Combat HIV/AIDS, malaria and other diseases

Target 7. Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Indicators:

18. HIV prevalence among pregnant women aged 15–24 years
19. Condom use rate of the contraceptive prevalence rate

19a. Condom use at last high-risk sex

19b. Percentage of population aged 15–24 years with comprehensive correct knowledge of HIV/AIDS

19c. Contraceptive prevalence rate

20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10–14 years

Continued on next page

development goals, including those contained in the Millennium Declaration, aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/ AIDS and eradicating poverty.

These commitments, along with human rights treaties more generally, have become a key platform for advocating the advancement of sexual and reproductive health internationally.

The Partnership for Safe Motherhood and Newborn Health, which was established in January 2004, promotes the health of women and newborns, especially the most vulnerable. The Partnership builds on the scope of the global Safe Motherhood Initiative and the work of the Safe Motherhood Inter-Agency Group. It aims to strengthen maternal and newborn health efforts at the global, regional and national levels, in the context of equity, poverty reduction and human rights. It focuses on the areas of advocacy and information-sharing, technical advancement and country-level support and partnership.

Acknowledging the significance of sexual and reproductive health for social and economic

Box 10 (continued)

ICPD goals and targets

ICPD Goals	Targets
Universal access to primary education	"…countries should….strive to ensure complete access to primary school or equivalent level of education by girls and boys as quickly as possible, and in any case before 2015" (paragraph 11.6)
Access to secondary and higher education	"Beyond the achievement of the goal of universal primary education in all countries before the year 2015, all countries are urged to ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, as well as to vocational education and technical training" (paragraph 4.18)
Reduction of infant and child mortality	"By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000. Countries that achieve these levels earlier should strive to lower them further" (paragraph 8.16)
Reduction of maternal mortality	"Countries should strive to effect significant reductions in maternal mortality and morbidity by the year 2015 (...) to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed" (paragraph 8.21)
Universal access to reproductive and sexual health services including family planning	"All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015" (paragraph 7.6)

A number of these goals and targets have been tailored to meet the specific context of the Western Pacific Region. For example, the maternal mortality goal has been recast as: "To reduce, by 2015, the maternal mortality ratio by 75% of the 1990 level, and to contribute to the reduction of infant mortality by reducing the number of neonatal deaths."

Sources: United Nations Millennium Project. 2006; WHO Regional Office for the Western Pacific 2005b.

development worldwide, the World Health Assembly adopted WHO's first Global Reproductive Health Strategy at its fifty-seventh session in May 2004 (Box 11). The global strategy strongly urges governments to fulfil commitments made at the ICPD, the Fourth World Conference on Women and their respective five-year review conferences. The resolution recognizes that accelerated action is critical for meeting the MDGs.

To this end, the strategy is designed to mobilize action in the following areas:

- strengthening health systems capacity
- improving information for priority-setting
- mobilizing political will
- creating supportive legislative and regulatory frameworks
- strengthening monitoring, evaluation and accountability

Member States are urged to use the strategy to develop and strengthen their reproductive health programmes and to meet their specific reproductive health needs. Almost all Member States of the World Health Assembly fully endorsed the strategy.

Box 11: Core components of the WHO Global Reproductive Health Strategy

1. Improvement of antenatal, perinatal, postpartum and newborn care
2. Provision of high-quality services for family planning, including infertility
3. Elimination of unsafe abortion
4. Prevention and treatment of sexually transmitted infections including HIV, reproductive tract infections, cervical cancers and other gynaecological morbidities
5. Promotion of sexual health

Source: World Health Organization. 2006e.

The political commitment for sexual and reproductive health, as illustrated by the range of international treaties and commitments, has not always been backed by adequate financial

resources. One 2005 estimate puts the annual cost of achieving the ICPD goals by 2015 at $23 billion (or $18.5 billion in 1994 dollars), with one third of this amount coming from donors. However, the ICPD estimates were based on a more modest set of actions. More recent estimates use revised figures to estimate the resources required to meet the ICPD goals by 2015 (Table 9).

Levels of donor funding for reproductive health initially declined during the post-ICPD period. For example, the World Bank's contribution to population assistance decreased from 25% of total global resources in 1994 to 10% in 2002. Since 2002, international assistance has begun to increase. However, funding for ICPD goals remains consistently below the financial estimates outlined in the ICPD PoA.

The recent trend towards increased funding for sexual and reproductive health can largely be explained by the increase in resources for HIV/ AIDS programmes. Funding for the prevention and treatment of HIV/AIDS (and STIs) often comes at the expense of family planning and other reproductive health programming. A recent report on financial flows to meet the ICPD goals concludes that while funding for HIV/AIDS programmes is rising, it remains below the levels required to meet current HIV/AIDS needs, which have outpaced those anticipated in 1994. In contrast to the improved financial flows to HIV/AIDS, funding for family planning has been steadily decreasing since 1994 and now stands at below the suggested target of $11.5 million in 2005. It is estimated that despite recent increases for sexual and reproductive health, international donors would have to triple the amount of funding dedicated to sexual and reproductive health to meet the ICPD goals. Nevertheless, many sexual and reproductive health interventions, such as maternal health services (Box 12), are still cost-effective investments.

National policies

Achieving the MDGs and ICPD goals, among other international commitments, requires broad and sustained political commitment for sexual and reproductive health at the national level.334 As such, broad-based political support must be generated for the rights-based approaches to sexual and reproductive health, which are expressed in international declarations and commitments.

Ministries of health can lead efforts to mobilize political support and buy-in for sexual and

Table 9: Revised total costs for achieving the ICPD Programme of Action

	US$ (2005) billions		
	2005	2010	2015
Basic reproductive health services (including family planning)	13.9	19.4	24.4
Sexually transmitted diseases and HIV/AIDS activities	4.1	9.7	11.1
Basic research data and population and development policy analysis	0.3	0.8	0.4
Total	**18.2**	**29.8**	**35.8**

Source: Vlassof and Bernstein 2006. In: United Nations Millennium Project 2006.

reproductive health from a range of stakeholders, including politicians, civil society organizations, academics, the private sector and diverse government ministries. Support from political leaders is vital to ensure that appropriate policies and plans are formulated and implemented. Support from poor and marginalized communities and groups, such as urban poor organizations and women's groups, can be leveraged to sustain upward pressure on political leaders over time. Box 13 discusses some reasons why sexual and reproductive health has remained a low priority among some decision-makers.

To be effective, however, political commitment needs to be translated into clear policy goals with dedicated financial and human resources. A clearly articulated national policy on sexual and reproductive health can create a framework to guide actions at all levels of the health sector. Many countries have had national population policies for decades. Following the ICPD, many of these national policies were revised and strengthened to reflect the priorities outlined in the ICPD PoA. According to WHO, the adoption of new reproductive health policies and programmes

Box 12: Maternal health services: a cost-effective investment

The World Bank estimates that, in developing countries, the financial cost of basic maternal and newborn health services is approximately $3 per person, per year, while maternal services alone cost as little as $2 per person. Safe motherhood initiatives are a sound investment, offering high social and economic returns at low cost. A recent study found that investments in maternal health, particularly antenatal care, can reduce maternal morality in low-income countries by an average of 26%. Providing essential obstetric services can reduce that figure by a further 48%. Estimating that women with complications from unsafe abortions occupy 20% to 50% of gynaecological wards in some countries and consume up to 50% of hospital budgets, investments in maternal care can significantly reduce hospital bed use.

Sources: World Bank 1993; Jowett 2000.

has led to significant changes in the delivery of maternal and child health or family planning services in some countries. Box 14 illustrates how enhanced political commitment has led to improvements in sexual and reproductive health in Brazil.

Of particular concern is how the goals of national sexual and reproductive health policies are worded. Evidence suggests that policies aiming to maximize health gains across the population may not have an impact on the health of marginalized or hard-to-reach populations, and may not address the different sexual and reproductive needs of men and

Box 13: Why has sexual and reproductive health not received higher priority?

Although the benefits of improved sexual and reproductive health for women's empowerment, gender equality and poverty reduction have been clearly documented, decision-makers and leaders at the national and international levels have not prioritized sexual and reproductive health for a number of reasons.

1. Sexual and reproductive health, as comprehensively defined in the ICPD PoA, recognizes the complex influences of economic factors, social dynamics and power relationships. This multifaceted understanding of sexual and reproductive health does not lend itself to a "quick fix" approach. Instead, it implies the need for a long-term multidimensional and multisectoral response. The responsibility for various aspects of sexual and reproductive health is distributed across different government departments and managers within departments, just as the concept is fragmented across assorted MDGs and other international goals.
2. Many core sexual and reproductive health approaches are preventive in nature. As with other preventive measures, it is difficult to measure progress and attribute success.
3. Many aspects of sexual and reproductive health are politically sensitive. Politicians and other community leaders are often hesitant to support such issues publicly.

Source: United Nations Millennium Project 2006.

Box 14: Political support for health reform enhances reproductive health in Brazil

In 1984, Brazil developed a comprehensive approach to women's health that included nearly all of the elements called for 10 years later at the ICPD in Cairo. However, for more than a decade, the programme remained isolated and under-funded and was never integrated into the national health system. Political turmoil and economic crises also hampered progress in reproductive health.

Since 1995, Brazil has had greater institutional capacity and a political climate favourable to the Cairo agenda. Reproductive health and rights also gained greater visibility as a result of Brazil's active participation in the 1995 Fourth World Conference on Women in Beijing. This renewed political interest, combined with reform of the health system, paved the way for substantial progress in the provision of reproductive health services.

The Government has advanced primary health care through community-based strategies that emphasize family health and has pushed for the decentralization of health services. Decentralization of the health system has put municipalities in control of budgets and the provision of services, which they can accomplish either through public health providers or contracts with private providers. Under the health system, all individuals are guaranteed access to a minimum package of basic health services, which includes family planning, prenatal care, maternity assistance and preventive services.

Is Brazil a model for other countries? Health systems cannot be replicated easily in another country because of unique social, political and economic circumstances. Nevertheless, reproductive health experts in Brazil have observed that the major principles underlying health reform—universal access, comprehensive care, equity (among different population subgroups), decentralization and public accountability—are necessary elements of a comprehensive approach to reproductive health. These reforms have been critical for addressing the wide inequalities in health status and access to care among the country's citizens.

Source: Ashford 2001.

women. Therefore, sexual and reproductive health policies need to be articulated in terms of both improving the health of all women and men and the health of those who are poor and marginalized. Expressing policy goals in these terms can help to explicitly integrate poverty and gender concerns into sexual and reproductive health policies.

Cross-sectoral action

Many of the determinants of sexual and reproductive health lie beyond the health sector. Therefore, action needs to extend beyond the health sector, particularly to national policies and plans related to poverty reduction and gender equality. Incorporating analysis of sexual and reproductive health into national poverty reduction plans and policies on gender equality and women's empowerment can address the multiple determinants of sexual and reproductive health. Such an approach also acknowledges the role that improved sexual and reproductive health can play in poverty reduction and women's empowerment.

The conceptualization of sexual and reproductive health adopted at the ICPD in 1994 involves a variety of interventions with a number of actors from diverse sectors, including education, finance, agriculture, youth, women's affairs and poverty reduction, among others. Strong links between the development of sexual and reproductive health policies and programmes and those of other relevant sectors can produce synergies. For example, improving women's education, access to economic opportunities and decision-making within households will enhance their access to sexual and reproductive health services.

At the global level, WHO has set up a Commission on the Social Determinants of Health to draw attention to how inequalities in health are produced and sustained by social factors and processes. The Commission's mandate includes making recommendations on how to reduce such inequities and improve the health of the poor through actions related to these social determinants of health.

At the national level, Poverty Reduction Strategy Papers (PRSPs) or other multisectoral socioeconomic planning instruments can offer an opportunity to increase policy coherence and undertake joint planning to address the determinants of sexual and reproductive health. PRSPs also aim to promote more effective resource mobilization and allocation. However, evidence suggests that, although PRSPs recognize sexual and reproductive health as a determinant of poverty, the PRSP process has not systematically incorporated attention to sexual and reproductive health. A recent review concluded that the record of incorporating population dynamics and reproductive health into PRSPs was disappointing. Ministries of health, therefore, need to secure a more central role in the PRSP process and to advocate for the inclusion of sexual and reproductive health within such multisectoral planning instruments. These arguments can be premised on the economic benefits of investing in sexual and reproductive

health and international commitments to promote and protect sexual and reproductive health and sexual rights, especially those of youth and women.

Similarly, creating an enabling environment for sexual and reproductive health extends beyond the health sector to include a range of national laws, regulations and policies that may determine the ability of men and women of all ages to enjoy good sexual and reproductive health. Laws and regulations in the areas of education, social welfare, infrastructure, justice, finance, employment and family affairs all impact upon sexual and reproductive health. A review and, where appropriate, amendment of laws, regulations and policies that affect various aspects of sexual and reproductive health can ensure that they are harmonized and that human rights of

Box 15: Including men in laws and policies to prevent and control HIV/AIDS among women and girls in Cambodia

When analysing the effect of laws, regulations and policies on particular aspects of the sexual and reproductive health of men and women, it can be useful not only to assess how a law, regulation or policy approaches a given issue or impacts different groups from a human rights and gender perspective, but also to consider what it addresses and omits. A powerful example of this approach comes from Cambodia in the area of HIV/AIDS prevention and control.

Traditionally, men of all ages have been excluded from education and services for sexual and reproductive health. The HIV/AIDS pandemic has increasingly highlighted the cost of such an omission in terms of men's health and the health and well-being of their wives, partners and children. In response, Cambodia's Ministry of Women's and Veterans' Affairs developed a gender-sensitive policy on "Women, the Girl Child and STI/HIV/AIDS". The policy acknowledges that the:

> *"recognition of gender and gender inequality should not lead to a sole focus on women. Globally, we have learned that HIV/AIDS projects that have focused solely on women in recognition of their need for empowerment have failed or been unsustainable because they have failed to involve men."*

The policy is premised on the recognition that HIV/AIDS is a gender-based pandemic and that curbing the spread of HIV/AIDS among women and girls also requires concrete changes in the sexual behaviour of men. The policy aims to put men's behaviour change on the agenda of policy-makers and service providers, along with prevention, care, support and protection for women and girls. This approach guides Ministry-supported activities in education, prevention and services provision.

Source: Ministry of Women's and Veterans' Affairs, Government of Cambodia 2003. In: Greene *et al.* n.d.

men and women are respected and promoted. Such analysis could assess whether laws adequately protect women and girls from gender-based violence, for example. This assessment should also consider how the implementation these laws, regulations and policies affect the sexual and reproductive health of individuals who are poor as compared to those who are non-poor. A recent review of the legislation in Mongolia, as it relates to HIV/AIDS prevention and control, concluded that the current legislation outlawing sex work should be revised to outlaw the act of hiring someone for purposes of prostitution. This shift in the law would effectively make the act of buying sex illegal (instead of selling sex, as it currently stands). Such a change, it is hoped, can decrease the vulnerability of many sex workers by encouraging them to dialogue with the police and to seek out government services, such as those for STIs. In addition, the process of developing laws, regulations and policies should respect, protect and fulfil the human rights of everyone. Box 15 discusses how legislation in Cambodia addresses gender inequality as it relates to HIV/ AIDS prevention and control.

Involving civil society organizations in processes to develop, assess and revise laws, regulations and policies can improve the transparency and accountability of such processes and thereby contribute towards building broad-based support for sexual and reproductive health.348 In addition, the participation of these organizations in the assessment and revision of sexual and reproductive health laws, regulations and policies can generate consensus and support for further action and implementation.

Health sector response

Achieving universal access to sexual and reproductive health services requires the integration of sexual and reproductive health into the institutions and structures of the health system.349 During the integration process, particular attention must be paid to ensuring that a full range of sexual and reproductive health services are available to all those in need. This approach to sexual and reproductive health was first outlined in the ICPD PoA and has since been elaborated in the WHO Global Strategy for Reproductive Health.

In many countries in the Region, responsibility for the development, implementation and evaluation of policies and programmes rests with different actors or departments. As various aspects of sexual and reproductive health tend to fall under different programmatic areas, such as HIV/AIDS, maternal and child health and adolescent health, collaboration between these and other priority programmes, such as malaria and tuberculosis, is required. In this context, the integration of sexual and reproductive health can be achieved through continuous, effective communication and collaboration between actors and departments to establish links at various levels of service delivery.

While communication and collaboration are critical to the successful integration of sexual and reproductive health services, these processes need to be supported by policies that strengthen health systems in three vital areas, namely, (1) appropriate arrangements for the financing of and payment for health services, (2) procurement and distribution of essential medicines, and (3) management of human resources. These policies are needed to ensure the integration of a full range of sexual and reproductive health services. Box 16 considers some of these issues with regard to the case of health sector reform. The sections that follow discuss health financing, human resources and health information for sexual and reproductive health as they relate to poverty and gender inequality.

Health financing

The manner in which revenue is raised and funds are allocated can influence access to sexual and reproductive health services for men and women, and poor and non-poor. Countries in the Region use various methods to determine how to mobilize and allocate resources in the health sector. One approach, which is becoming increasingly popular, is the sector-wide approach (SWAp). SWAps and similar methods for allocating resources tend to rely upon priority-setting measures such as DALYs. However, such measures have been demonstrated to undervalue sexual and reproductive health needs, including maternal health care. When

Box 16: Health sector reform and sexual and reproductive health

Health sector reform profoundly alters how health services are financed and delivered, in turn influencing how sexual and reproductive health care is provided. Many reproductive health priorities, such as improving service quality and client satisfaction, educating patients and providing more choices are consistent with health sector reform. However, reforms inevitably involve trade-offs and can have negative effects. Reproductive health managers and advocates interested in influencing how services are funded and provided need to become familiar with the objectives, principles and strategies of health sector reform and take part in policy discussions at the national and local level. The following are some ideas on what can be done:

Engage in continuous dialogue with health planners. Mechanisms may vary from country to country, but groups working on health sector reform and sexual and reproductive health need to share information regularly. Sexual and reproductive health specialists need to be involved when critical decisions about the financing, organization and regulation of services are made. Having allies inside the government can be essential for gaining access to the process.

Show that reproductive health is a good investment. To influence the reform agenda, advocates must prove to policy-makers that sexual and reproductive health accounts for a significant proportion of the country's overall disease burden and has social implications beyond the burden of disease; that interventions for sexual and reproductive health are cost effective; and that gross inequalities in reproductive health status and the allocation of resources can and should be addressed.

Use participatory approaches to influence decisions and monitor progress. Participatory processes that establish clear programme goals and measurable indicators of progress can be essential in bringing together health reformers and reproductive health advocates. Donors might consider investing in increasing the technical and analytical capacity of local administrators and civil society organizations to help those groups take part in shaping health reform.

Health sector reform has the potential to improve both the quality and the sustainability of sexual and reproductive health services, but its success depends in part on participation from a range of stakeholders. Local health administrators must be able to solicit and use the input of diverse stakeholders, and to address reproductive health issues in a transformed health system.

Source: Dmytraczenko *et al.* 2003.

plans for resource allocation are formulated, sexual and reproductive health must be prioritized. In a similar manner, the formulation of an essential package of services must include sexual and reproductive health services that meet the needs of the target population. Most countries in the Region finance the health sector through a combination of revenue-raising mechanisms: taxes, social health insurance, donor funding, prepayment schemes, private health insurance, and/or out-of-pocket payments or user fees. Table 10 presents some of the public financing mechanisms employed by countries in the Region, as a percentage of the total revenue.

In practice, private financing in most countries takes the form of out-of-pocket payments at the point of service. Analysis suggests that taxes and social insurance schemes offer the most equitable form of health financing. Social insurance and other prepayment schemes tend to cover services that meet the needs of the target population in a cost-effective manner; however, as with resource allocation more generally, they have also been shown to undervalue sexual and reproductive health needs. These types of schemes, for example, tend to exclude routine contraceptive and delivery care for women, thereby resulting in unnecessary

Table 10. Public financing mechanisms for the health sector in selected countries in the Region in 2001

Country	Tax revenue	Social insurance	External assistance
Cambodia			51.0%
China		87.0%	
Japan		89.0%	
Lao People's Democratic Republic	86.3%		
Malaysia	98.8%		
Mongolia	76.5%		
Papua New Guinea	83.5%		
Republic of Korea		71.9%	
Viet Nam	93.3%		

Source: Musgrove *et al.* 2001. In: Ravindran 2005.

Caesarean sections and other surgical procedures, which are more often covered. Insurance schemes also tend to exclude pharmaceuticals that are not prescribed by a health provider,

such as oral or emergency contraception. In addition, key aspects of sexual and reproductive health care are preventive rather than curative. As such, priority setting for social insurance and other prepayment schemes need to include other criteria to promote, rather than discourage, the availability of sexual and reproductive health services.

In addition to the range of services covered by insurance, the criteria used to identify who is eligible for coverage have important implications for sexual and reproductive health. For example, detailed analysis suggests that women may enjoy lower access than men to social insurance schemes financed through payroll deductions, because of their lower participation in formal wage labour. Social insurance and other prepayment schemes might also exclude same-sex couples. Financing sexual and reproductive health services through tax revenue may be a more effective means of ensuring that these services are accessible to poor and marginalized groups.

Greater reliance on private for-profit health insurance and direct user fees in many countries appears to have adversely affected the access of the poor to health services. Reliance on for-profit service providers tends to leave poor and marginalized communities underserved. Analysis of experience in 39 countries suggests that the introduction of user fees increased revenue to the health sector only slightly, while significantly reducing access to basic health services for low-income people. Evidence suggests that women have been disproportionately affected as compared to men by the increasing reliance on user fees and may enjoy lower coverage of health insurance schemes. While social marketing campaigns may reach some motivated individuals, they are unlikely to meet the needs of poor households who may depend on subsidized contraceptives to meet their family planning needs.

Human resources

Human resource policies can have major implications for the effective delivery of sexual and reproductive health services. Human resources need be distributed in a manner that meets the health needs of the population generally, such as by ensuring adequate numbers of trained staff in rural and remote health centres and in urban poor communities. - e allocation of health staff between primary, secondary and tertiary levels also influences the capability of the health system to adequately respond to the sexual and reproductive health needs of men and women. Appropriate human resource policies can create a workforce that is motivated and competent. For example, sexual and reproductive health issues remain taboo in many areas and can be a source of embarrassment where men or women are made to seek care from a health service provider of the opposite sex. Women frequently cite the absence of a woman health professional as an important reason for not seeking treatment. Because of this, it is vital to ensure the availability of both male and female health staff.

Good coordination can promote the successful delivery of sexual and reproductive health services. Timely referrals to higher levels of services are critical for obstetric emergencies, for example. Indeed, timely emergency care has been identified

Box 17: Example of a prepayment scheme that includes reproductive health services in the benefits package

Bolivia formulated the Maternal and Child National Insurance Plan in 1996 to improve the coverage of maternal and child health care. The programme finances the total costs of antenatal care, labour and delivery, including Caesarean sections and other obstetric emergencies, postpartum care and newborn care for women and children under five years of age. The insurance package does not cover contraceptives.

Between 1994 and 1998, the proportion of births with a skilled birth attendant increased from 43% to 59%. Disaggregating these data further shows that the use of skilled birth attendants increased from 11% to 20% among the poorest income quintile. An evaluation conducted in 1998 of the National Insurance Programme for Mothers and Children (SNMN) in Bolivia concluded that the benefits of the programme were disproportionately enjoyed by poor households. Among clients seeking care for maternal care, for example, 68% were from households classified as having low socioeconomic status and 32% were belonged to middle-socioeconomic status households.

Source: Dmytraczenko and Scribner 1999.

as a core aspect of strategies to reduce maternal mortality. Coordination between voluntary testing and counselling for HIV and STIs and family planning services can create positive synergies for sexual and reproductive health. Links also tend to extend from the health system to volunteer or community-based health workers. Evidence suggests that trained traditional birth attendants can successfully identify early signs of complication during labour and delivery and refer women for treatment. Other actors may also be involved in the provision of services

for sexual and reproductive health, such as private providers and nongovernmental organizations (NGOs). Often, mid-level professionals and paramedical workers provide many core sexual and reproductive health services. Respectful working relationships with health providers beyond the health sector can further enable the delivery of comprehensive, good-quality sexual and reproductive health services.

Health workers require continuous training and capacity-building to ensure that they have up-to-date knowledge and skills. Access to current knowledge and research on various sexual and reproductive health issues can also enable health staff to better counsel and advise patients. This includes ensuring that men and women clients are fully informed of their options, such as likely benefits and potential side-effects, and that properly trained personnel obtain voluntary and informed consent from clients.

Enhancing the awareness of health staff on human rights and gender-sensitive standards can further improve the delivery of sexual and reproductive health services and ensure that they meet international standards, such as those laid out in the ICPD. Such an approach can include redesigning services and training for health workers so that they are gender-sensitive and reflect the user's perspectives with regard to interpersonal and communication skills as well as the client's right to privacy and confidentiality. Given the sensitive nature of sexual and reproductive health in many communities, health service providers need to be particularly considerate of the needs and perspectives of their men and women clients. Privacy and confidentiality are critical to young people seeking sexual and reproductive health services. Not only do health centres need private spaces for counselling and consultation, but health providers must also strive to offer confidential services to all patients.

Health information

To be effective, sexual and reproductive health policies need to be grounded in an analysis of timely and accurate data and research on the sexual and reproductive health needs of the population, including those of various groups within society, such as women and men and those who are poor or live in rural areas. In addition, policies need to be based on a thorough understanding of the social, cultural, political and economic dynamics and trends that influence the sexual and reproductive health of men and women of all ages. This information must then be analysed and used to guide the allocation of financial and human resources for sexual and reproductive health in the most equitable and effective way.

Equipped with sound evidence, advocates can advance efforts to build broad-based political support for sexual and reproductive health. That

Box 18: Reproductive health indicators

1. Total fertility rate
2. Contraceptive prevalence rate
3. Maternal mortality ratio
4. Percentage of women attended, at least once during pregnancy, by skilled health personnel (excluding trained or untrained traditional birth attendants) for reasons of pregnancy
5. Percentage of births attended by skilled health personnel (excluding trained and untrained traditional birth attendants)
6. Number of facilities with functioning basic essential obstetric care per 500 000 population
7. Number of facilities with functioning comprehensive essential obstetric care per 500 000 population
8. Perinatal mortality rate, by sex
9. Percentage of live births with low birth weight (<2500 grams)
10. Positive syphilis serology prevalence in pregnant women aged 15 to 24
11. Percentage of women of reproductive age (15–49) screened for haemoglobin levels who are anaemic
12. Percentage of obstetric and gynaecology admissions owing to abortion
13. Reported prevalence of women who have undergone female genital mutilation
14. Percentage of women of reproductive age (15–49) at risk of pregnancy who report trying for a pregnancy for two years or more
15. Reported incidence of urethritis in men aged 15–49

Adapted from World Health Organization 1997.

misconceptions must often been confronted and dispelled as part of the process of mobilizing political support for sexual and reproductive health. For example, much resistance to curriculum-based sex education is premised on the notion that providing young people with such information will increase the likelihood that they engage in premarital sex. Available evidence suggests that this belief is unfounded and that curriculum-based sex education does not lead to increased risky behaviour among youth.363 - ose advocating for sexual and reproductive health should thus be armed with locally specific evidence and research to dispel commonly held beliefs that hinder the development and implementation of sexual and

reproductive health policies. Such evidence can also be useful in training and capacity-building for health staff, as well as in setting human resource policies.

To this end, sexual and reproductive health indicators need to be integrated into national planning tools in addition to those indicators collected by the health sector. Box 18 provides a minimal list of reproductive health indicators for use at national and global levels. This is not a comprehensive set of indicators for programme monitoring and evaluation. Instead, the objective of this list is to identify a limited number of indicators that can offer a general overview of the reproductive health situation in a given setting.

To produce a comprehensive overview of a country's sexual and reproductive health needs, data on indicators need to be collected for the population as a whole and for specific groups.365 To determine how, if at all, the distribution of sexual and reproductive health varies among vulnerable groups within society, adequate data must be collected to assess these differences by sex, income, employment and education status, ethnicity, urban-rural location, region or province, or other relevant indicators of disadvantage. Box 19 describes criteria on which to base gendersensitive indicators. Gender-sensitive indicators enable us to explore how gender inequality influences the sexual and reproductive health of men and women.

Box 19: Developing gender-sensitive indicators for reproductive health services

Comparison to a norm: Indicators should involve comparison to a norm, for example, the situation of men in the same country or the situation of women in another country. In this way, the indicator can focus on questions of gender equality and equity rather than only on the status of women.

Disaggregation: Data should be disaggregated by sex. Whenever possible, national-level indicators should also be disaggregated by age, socioeconomic grouping, urban and rural setting, ethnicity and national and/or regional origin. The time period, geographical coverage, and data sources should be noted.

Ease of access: Data should be easy to use and understand. Indicators should be phrased simply and should be developed at a level relevant to the institutional capabilities of the country concerned.

Scope of availability: Indicators should be available for the whole country.

Reliability: Data should be relatively reliable. No data is absolutely reliable but reliability checks should be carried out. For example, findings from consensus should be compared to findings from micro-level studies for accuracy.

Measurability: Indicators must be measurable. Concepts such as 'women's empowerment' and 'women's equity' may be difficult to define and measure. In this case, indicators that measure women's access to health care or education may be used instead of the less precise concepts.

Time frame: Gender-sensitive indicators should be reliable enough to use as a time series. The time frame that the indicator covers should be clearly specified.

International compatibility: Gender-sensitive indicators should use internationally accepted definitions. While definitions are sometimes imprecise, they are usually the best terms available and allow for international comparisons.

Measuring impact: Gender-sensitive indicators should, where possible, measure the outcome or impact of a situation rather then the input. For example, female mortality rates are a better measure of women's health status than access to health facilities.

Participation: Indicators should be used and developed in a participatory process. This process will involve setting up interdepartmental government committees and holding focus group meetings with the public to elicit the opinions of women and men whenever possible.

Source: Commonwealth Secretariat. In: Baume 2001.

Once collected, data should be disaggregated and analysed by socioeconomic status, sex, urban-rural location, ethnicity and other relevant indicators of social exclusion. Through this process, analysts would learn how sexual and reproductive health-related morbidity and mortality are distributed among the population generally and within specific subgroups, such as the urban poor and ethnic minorities. Disaggregated analysis can also refine understanding of unmet needs, such as family planning services. Employing gender analysis can also reveal how gender roles, such as the gender division of labour, gender norms and access to and control over resources, influence the sexual and reproductive health of men and women across the life cycle. This analysis can then guide the identification of effective, appropriate and equitable policies and interventions for sexual and reproductive health.

Data collection and analysis should be supplemented by case studies and other

Box 20: Strengthening reproductive health programmes

Planning process questions

- What is the current reproductive health situation? What are the needs? They should be identified through situation analysis or a needs assessment.
- What has been done to address the current situation? Programmes should be developed through strategic planning to bring about change or improve a specific situation through appropriate interventions.
- How should progress and achievements be monitored and evaluated? Programme evaluation should be integrated into the strategic plan to assess the effectiveness/impact or the outcome of its intervention(s).

Programme managers should:

- determine available resources and tools for various aspects of reproductive health;
- produce evidence-based and culturally sensitive information, education and communication messages; and
- explicitly involve all key stakeholders in the planning and implementation process.

The strategic planning process should:

- identify relevant background information based on a situation analysis;
- identify priority interventions;
- develop objectives and strategies with a work plan containing key activities, indicators, time frame, estimated cost, proposed evaluation and assignment of responsibilities.

The strategic framework should take into account the following key elements:

- creation of an enabling environment through advocacy and social mobilization that targets the relevant communities, policy-makers and all key stakeholders;
- promotion of healthy reproductive health behaviour;
- promotion of equitable access to quality health services while improving provider-client relationships and best practices in the context of national policy;
- providing opportunities for training through workshops and other capacity-building activities;
- fostering collaboration, partnership and strong reproductive health networks;
- developing a research agenda and strengthening the dissemination and utilization of research information, including a commitment to improve access to and quality of reproductive health programmes.

Adapted from World Health Organization 2002a.

qualitative methods of research in order to assess unmet needs for sexual and reproductive health services, perceived quality of health services, and various financial and non-financial barriers that poor men and women may face when accessing services for sexual and reproductive health. Case studies and other qualitative analytical methods can provide information that an analysis of data from health information systems would otherwise miss.

Once collected and analysed, quantitative and qualitative information can be harnessed to develop sexual and reproductive health policies or to advocate for increased political and financial support for sexual and reproductive health. Box 20 provides guidance for programme managers in outlining a strategic plan for developing and strengthening reproductive health plans at the national and district level. Such strategic planning entails the adaptation of norms and/or tools to a given or changing situation. It takes into account the underlying determinants or variables that affect the delivery of reproductive health care such as gender and sociocultural perspectives.

Building coalitions with diverse organizations can also ensure that the process for formulating sexual and reproductive health policies and plans are informed by the needs of the poor and of men and women. Strong links with marginalized groups, for example through civil society organizations, can help to elucidate the views and needs of poor individuals and of men and women. This can be achieved through participatory methods, community consultation or identification of representatives from these groups to sit on a policy advisory board. Involving men and women and those who are poor and marginalized can ensure that policies and plans are better tailored to meet their sexual and reproductive health needs.

Service delivery

Providing sexual and reproductive health care in an integrated manner has important implications for how services are delivered. - e aim of integration is to improve the overall effectiveness and efficiency of service delivery and to meet the needs of all people for "accessible, acceptable, convenient and client-centred comprehensive care." At the point of service delivery, the integration of sexual and reproductive health care means bringing together all aspects, such as those outlined in Box 10, and building strong working relations with other health services and, where appropriate, with related social services. Ideally, this approach should include preventive measures, the provision of information and counselling to clients in addition to screening, diagnosis and curative care.

All of these services do not need to be provided in the same health clinic or site. Instead, health service providers need to be equipped with the knowledge and skills to provide an appropriate package of basic services and to refer patients to required services that are lodged in other areas or levels of the health care system. Decisions concerning which services to offer and

which to link through referral systems need to take into account the capacity of the health system, including the knowledge and skills of health service providers, and the perspectives of local communities. The manner in which these services are delivered also needs to respond to gender and poverty concerns to address inequalities in sexual and reproductive ill-health.

The following section presents information on innovative strategies that health professionals are employing to improve the accessibility of health care for the poor and to ensure that men and women benefit equally from resources allocated to sexual and reproductive health. These interventions are still in their early stages and have not yet been rigorously evaluated or standardized. However, they suggest some ways forward. Each strategy must be refined based on further analysis and country-specific situations. This is not an exhaustive list of strategies, as the evidence base for equity-promoting and gender-sensitive strategies needs to be augmented through more systematic operational research.

Addressing geographical barriers

The coverage of health services in many developing countries in the Region remains incomplete and the distribution of available services often benefits non-poor communities to a greater extent than those that are poor. Among countries in the Pacific, for example, health services may not effectively cover remote and small island communities. Limited coverage of health facilities constitute geographical barriers that may prevent or delay care-seeking by poor individuals. Travelling long distances for health care may be more difficult for women than for men, whose mobility may be restricted by social norms or by limited access to cash income and household resources.

Primary health facilities are often more accessible for poor households than are services offered in secondary or tertiary level facilities, which tend to be concentrated in urban centres. This greater accessibility of primary health facilities was recognized in the ICPD PoA, which committed countries to provide a full range of sexual and reproductive health services in an integrated manner within the primary health system. Prioritizing sexual and reproductive health services that can be successfully integrated into primary health facilities can be an effective method of increasing the geographical accessibility of these services to poor men and women.

An approach that prioritizes the delivery of sexual and reproductive health services through primary care facilities may require improved coverage of appropriate diagnosis and treatment methods. That is, primary health care facilities require simple, low-cost methods for the diagnosis and treatment. Box 21 discusses advances in simple, low-cost technologies to diagnosis cervical cancer.

While the primary health care system in many countries is quite extensive, some areas remain beyond its reach. Financial incentives can encourage local NGOs and private providers to offer appropriate sexual and reproductive health services in such areas. Partnering with NGOs might be especially fruitful for scaling up sensitive components of sexual and reproductive health services.

NGOs working with youth in rural and remote communities, for example, may be persuaded to integrate adolescent reproductive health services into their programming. Financial incentives may also motivate alternative health service providers to enter into underserved areas. Cambodia, for example, has successfully employed a strategy of contracting NGOs to provide health services in several districts, thereby increasing the accessibility of health services, often to the benefit of the poor. Contracting with private providers is increasingly used to improve the accessibility of sexual and reproductive health services. In areas where poor individuals consult private practitioners, coordinating between private and public providers can improve the coverage and quality of services.

Regular outreach services in poor and remote communities can bring sexual and reproductive

Box 21: Visual inspection with acetic acid wash for cervical cancer

Cervical cancer is one of the most common forms of cancer among women in low-income settings. An estimated 80% of deaths from cervical cancer occur in developing countries. Among women in low- and middle-income countries, the majority of cervical cancer cases are caused by infection with a subtype of human papillomavirus (HPV). HPV is a sexually transmitted virus that infects cells and may led to precancerous lesions and invasive cancer.

Cervical cytology programmes, which screen sexually active women annually or once every two to five years, have resulted in a large decline in cervical cancer incidence and mortality in developed countries. To be effective, cervical cytology programmes require established laboratories, highly trained cytotechnologists and up to three visits for screening, evaluation of cytologic abnormalities and treatment. This approach has remained largely ineffective in developing countries, where organized programmes are limited and testing is often of poor quality and performed inadequately. In recognition of these constraints, alternative methods based on visual examination of the cervix have been investigated.

Among these approaches, visual inspection with acetic acid (VIA) has received the most attention. VIA involves swabbing the cervix with diluted (3%–5%) acetic acid and then examining it with the naked eye, i.e. without any magnification; illumination is provided by a bright source of light. Nurses or other paramedical health workers usually perform this test. To be considered positive, the test detects well-defined, dull acetowhite lesions on the cervix. This detection aims for the early diagnosis of high-grade cervical intraepithelial neoplasia and early preclinical, asymptomatic invasive cancer.

Evidence suggests that VIA has similar sensitivity to that of cervical cytology, but with lower specificity. Because the outcome of VIA is known immediately, it reduces the amount of time women must devote to screening procedures. VIA has been found to be cost effective, as it decreases the direct medical cost of screening to the health system and the patient.

Sources: Sankaranarayanan *et al.* 2001; Goldie *et al.* 2005; World Health Organization 2002c.

health services closer to those in need. Outreach services include regular health staff visits, mobile clinics and village health posts. Outreach services have been used to provide contraceptives in hardto-reach communities. Outreach services need to be tailored to meet the needs of specific sub-populations, such as ethnic minorities, island communities and migrants. A case study from Vietnam (Box 22) provides an example of how one

Box 22: Reaching the poor and ethnic minority families in Viet Nam

Ethnic minorities account for more than half of the population in three of the provinces served by the Population and Family Health Project in Viet Nam. To ensure that women in remote mountainous areas have access to improved health and family planning services, two model outreach programmes are being tested. Village health posts are being established together with a hamlet-based "collaborator" network. Locally selected collaborators are being provided with bicycles to ensure that health care is available to settlements when they need it.

Staff trained within the ethnic communities supplement the hamlet-based collaborators. Improved clinical training is also being provided to women health and family planning workers. More women are being trained as health workers, nurses, midwives and doctor's assistants. If successful, these outreach programmes will be replicated in the other 12 provinces of Viet Nam, where the project is upgrading and expanding health and family planning services.

To reach women unfamiliar with the services being offered, the project includes the use of innovative social marketing methods, such as the use of non-traditional outlets to promote new services. Through the project, thousands of Vietnamese women are starting to experience improved care in pregnancy and during deliveries. Access to a wider range of contraceptives is now available for women and men. As their health improves and they are able to control the birth spacing of their families, women are becoming better equipped to move out of poverty and into a productive life.

Source: Asian Development Bank 2002.

programme addressed the problem of providing effective and accessible reproductive health care to an ethnic minority group. Box 23 discusses the mobile reproductive health clinics run by the Self-Employed Women's Association (SEWA).

Communities play an important role in the delivery of health services in countries throughout the Region. Their involvement ranges from the recruitment of community-based health workers to increasing reliance on home-based care for chronic illnesses, such as HIV/AIDS. Other approaches aim to mobilize the participation of communities in decisions that affect their health. While such strategies can effectively extend the reach of the health system and improve its responsiveness to communities, the benefits of community-based approaches cannot be guaranteed. For example, power dynamics within communities may silence the voices of marginalized members, such as women and individuals from poor households; youth may also experience difficulty expressing their opinions in arenas that include their parents, teachers and community leaders. Care also needs to be taken to ensure that women's unpaid work burden is not increased in the process, as in many areas, the work of caring for the ill at home is often viewed to be the responsibility of women and girls. Approaches that are sensitive to these and other issues can better ensure that the interests of such groups feature in planning and implementation processes.

Addressing economic barriers

The mix of financing mechanisms adopted to fund health services largely determines the economic accessibility of sexual and reproductive health services. As discussed above, careful planning can tailor the mix in such a way as to reduce the possible adverse effects on women as compared with men and those who are poor as compared with those who are better-off. Once these mechanisms have been decided upon, additional strategies can be employed to further improve the economic accessibility of sexual and reproductive health services. To be effective, such strategies

Box 23: Mobile reproductive health clinics serving the very poor in India

The Self-Employed Women's Association (SEWA), a trade union of informal women workers, was founded in 1972 in Ahmedabad, Gujarat. The aims of SEWA are: (1) to organize women to achieve full employment (work security, income security, food security and social security), and (2) to make women independently and collectively self-reliant, economically independent and capable of making their own decisions.

SEWA has been involved in public health initiatives and the delivery of health services to members and non-members since the early 1970s. The primary objective of these initiatives has been to provide services to the very poor, particularly those who live in areas that are not otherwise served by the government or NGOs.

In response to the need for reproductive health services for women in remote and underserved areas, SEWA organized mobile reproductive health clinics in 1999. The mobile clinics initially provided services in slum areas of Ahmedabad city and villages in three districts. The clinics are largely funded by UNFPA and the Government of India.

The mobile clinics usually operate for three to four hours in the afternoon and provide health education and training, examination and diagnostic tests (including cervical examination and Pap smears), treatment, referral and yearly follow-up visits to each target area. Physicians and community health workers staff the mobile clinics, which see an average of 30 women per month. Women who attend the mobile clinics are requested to make a contribution of 5 rupees ($0.11) and to pay one third of the total costs of the medicines provided.

More recently, SEWA has been collaborating with the government of Gujarat to hold mobile camps in public health centres in rural areas of the province. In contrast to the standard mobile clinics, services are provided by public doctors and nurses and medication is available free of charge. In addition, SEWA covers the transportation costs of women living in neighbouring villages.

A recent evaluation concluded that the urban mobile clinics were successful in reaching the very poorest, while the rural camps were less effective. The success of urban camps was attributed to design of the mobile clinics, which brings services and education to poor people and incorporates poor people into the delivery of many, if not all, health services. In addition, the mobile clinics are often combined with initiatives to mobilize and educate the larger community and the costs of services are significantly lower than those by other local service providers. Finally, SEWA is a well known and trusted institution in Ahmedabad city. SEWA health providers also attributed their success to the warm and respectful way they treat their clients and that fact that most health providers are women.

While the reasons for the limited success of the rural clinics in reaching the poorest remain largely unexplored, some contend that the registration fee may prevent very poor women from seeking care and that the clinic hours tend to conflict with the working hours of many rural women.

Source: Ranson *et al.* 2005.

should be informed by research and analysis that considers how the various financial mechanisms adopted affect the accessibility of sexual and reproductive health services for various groups. For example, evidence from Cambodia suggests that, in some areas, condoms are available free of charge to women sex workers, while in others they must be bought from health facilities, brothel owners or NGOs. Such detailed analysis can identify how to address economic barriers, such as through exemptions targeting vulnerable groups of adolescents, unmarried mothers or ethnic minorities. Other strategies can include exempting priority health services from user fees. Ghana, for example, adopted a policy of free delivery care for all women. Instead of financing deliveries through user fees, as is the case with other health services, the Government opted to finance this priority service

Box 24: Improving the economic accessibility of delivery care for women in Nepal

The costs associated with delivery care in Nepal, most notably transportation, are considerable. Evidence shows that they prevent or deter women from accessing delivery care, thereby hindering progress towards the Government's goal of increased skilled attendance at birth.

To address the economic barriers to delivery care, the Government of Nepal, in July 2005, introduced a new policy that provides:

1. transportation allowances for all women who deliver with a skilled attendant (payment varies depending upon the topology of the area);
2. financial incentives for skilled birth attendants who assist deliveries; and
3. free institutionalized delivery care in the poorest districts.

During the first year of implementation, less than half of the districts had initiated the new policy measures. While an increase in deliveries with skilled birth attendants has been observed, it is still too early to assess the impact of this policy on the poorest districts and on the health of women and children in Nepal.

Source: Borghi *et al.* 2006.

through the PRSP process. Box 24 describes the Government of Nepal's policy to provide cash payments to women for transportation costs and free institutional delivery for women residing in the poorest districts.

Financial incentives constitute an innovative approach to improving access to sexual and reproductive health services by stimulating demand among specific groups. For example, conditional cash transfers have been shown to be an effective method for improving access to selected sexual and reproductive health services for poor households in Latin American countries. Conditional cash transfers aim to mobilize demand for a given health service among the targeted community. More specifically, these schemes transfer a set amount of money to preidentified families, or individuals within families, conditional on certain behaviours or actions, such as their use of specific services. Evaluations report that conditional cash transfer schemes have increased uptake of antenatal care by 8% during the first trimester of pregnancy in Mexico, and by 15%–20% in Honduras, especially among poorer households.

Many developing countries have used voucher schemes to generate demand for sexual and reproductive health services. This approach provides vouchers to targeted individuals or households, which can be exchanged for a pre-identified service, such as maternal care or diagnosis and treatment for STIs. These services are often delivered in health facilities that have been contracted in advance to provide the redeemable services. - is approach is seen to be particularly effective because it overcomes the challenges associated with cost-sharing schemes that require advanced payment for care. Box 25 describes the experience with vouchers in meeting the sexual and reproductive health needs of adolescents in low-income areas of Managua, Nicaragua.

Community-based health insurance schemes, which generally operate on a much smaller scale than other types of insurance schemes, have been established in many areas. Such schemes spread the financial burden of ill-health across households in the community and over predictable periods of time. However, community-based insurance schemes may not cover sexual and reproductive health services that are considered sensitive, such as family planning and post-abortion care. Similarly, these schemes may exclude people who are deemed to not need particular services, such as unmarried adolescents and ageing men and women. Experience also shows that these schemes are not always accessible to poor households, who may not be able to make the required prepayments.

Addressing sociocultural barriers

While prevention, diagnosis and treatment can improve the well-being of men and women, the

Box 25: Meeting the sexual and reproductive health needs of female adolescents in low-income urban areas through a voucher scheme in Managua, Nicaragua

Nicaragua is one of the poorest countries in Latin America. Of the 5.2 million people living in the nation's capital, Managua, 25% are between the ages of 10 and 20 years. The adolescent fertility rate is one of the highest in Latin America, with 119 births per 1000 women (15–19 years of age). By the age of 19 years, 45% of young women either are mothers or are pregnant. Contraceptive use among adolescents is low, as is the use of sexual and reproductive health services. Limited access to information and poor quality of care have been held responsible.

In response, the Central American Health Institute (ICAS), in partnership with the London School of Tropical Medicine and Hygiene, launched an innovative pilot project to improve the use of quality sexual and reproductive health care among adolescents in poor and underserved areas of Managua. The pilot project, which was funded by the Department for International Development of the United Kingdom, aimed to increase demand for sexual and reproductive health services through a competitive voucher scheme.

Through the project, 28 711 vouchers were distributed to male and female adolescents in poor and underserved areas of Managua from September 2000 to July 2001. The vouchers were issued by ICAS and distributed by ICAS and NGOs in markets, outside public schools, in clinics, on streets and in poor neighbourhoods (house-to-house).

Valid for three months, the vouchers were redeemable for one consultation and one follow-up visit for counselling, family planning, pregnancy testing, antenatal care, STI treatment or a combination of these services. The voucher did not have to be used by the person who originally received it and could instead be passed on to another adolescent. Adolescents who redeemed their vouchers for services also received a booklet on adolescent health, two condoms as well as any necessary laboratory tests, drugs and contraceptives.

Continued on next page

promotion of sexual and reproductive health must often confront sensitive and contentious issues. This is because sexual and reproductive health initiatives often need to challenge social norms, conventions and stereotypes. Sociocultural issues also influence the appropriateness and efficiency of policies and programmes for sexual and reproductive health in different settings. Experience suggests that local ownership and the empowerment of stakeholders is fundamental to the success of development programmes, including sexual and reproductive health initiatives. As such, sociocultural barriers need to be identified and acknowledged as both challenges and opportunities for the realization of sexual and reproductive health.

Approaches to sexual and reproductive health that seek to tackle sociocultural barriers can create tension and conflict with local communities, particularly where efforts aim to change

social norms, social relations and power dynamics in households, communities and societies.376 Individuals or groups who feel threatened by the intervention may react negatively and hinder activities. However, individuals, communities, their representatives and institutions are the main drivers of change. Thus, to influence social norms to improve the sexual and reproductive health of men and women, strategic alliances need to be forged with these actors to mobilize support and strengthen ownership.

Efforts to tackle sociocultural barriers, such as gender norms and notions of appropriate sexual behaviour for young men and women, must be founded on an understanding and appreciation of local cultures and the differences, conflicts or hierarchies between various actors. To this end, health staff need to listen and learn from communities. Partnerships based on trust and open dialogue can be supportive of positive

Box 25 (continued)

The vouchers were redeemable at 20 clinics: four public, five private and 11 run by NGOs. These clinics were selected on the basis of suitability (such as prior experience with sexual and reproductive health) and proximity to the targeted areas. Staff at participating clinics attended a short introduction to the programme and were encouraged to attend training sessions on counselling, adolescent sexuality and sexual abuse. Clinics received reimbursement according to agreed-upon fees. The average price per consultation and follow-up visit was $4.56.

Of the vouchers distributed, 20% of those issued to girls and 6% of those issued to boys were redeemed. In total, 3067 female adolescents used 3301 vouchers, of which 34% were for family planning, 31% for treatment of RTIs and STIs, 28% for antenatal care, 28% for counselling, 18% for pregnancy testing and 15% for other reasons. The majority of vouchers were redeemed at NGO clinics.

An evaluation of the impact of the pilot programme on female adolescents concluded that, after controlling for different characteristics, the vouchers had significantly increased the use of sexual and reproductive health services, knowledge of contraceptives and knowledge of STIs and prevention with condoms among those who had redeemed vouchers as compared with those who had not. The increase in use of sexual and reproductive health care was most marked among younger female adolescents, those still in school and those with the lowest level of education. In particular, female adolescents who were neither pregnant nor mothers were found to benefit the most from increased access to sexual and reproductive health services.

The results of focus group discussions revealed that the voucher programme had increased the use of sexual and reproductive health services by eliminating out-of-pocket payments for services, removing the need to make an appointment, and informing female adolescents of clinic hours of operation and locations. In addition, the guarantee of confidentiality by a health provider of choice was identified as key in convincing adolescents to seek sexual and reproductive health services.

Sources: Meuwissen *et al.* 2006a, 2006b and 2006c.

change and knowledge-sharing for improved sexual and reproductive health. In particular, it is vital that sexual and reproductive health initiatives avoid language and practices that are judgmental of cultures and social practices. For example, an effective way of engaging with cultural norms and institutions is to make no value judgement on particular cultural practices, while advocating against traditional practices that breach human rights and have negative effects on maternal and child health. One strategy that has proven to be effective is to engage local power structures and faith-based institutions (Box 26). Such organizations are often willing to cooperate on sexual and reproductive health initiatives when they are engaged in a culturally informed and sensitive manner based on relevant evidence and information. As well, these types of interventions often need to be carried out over time, as short-term change may not be unsustainable.

Participatory methods that engage with and respond to the perceptions, views and needs of all community members are often more effective in creating social change than are top– down interventions initiated by organizations or individuals outside the community. Such participatory approaches can be used to determine the sexual and reproductive health needs of communities and to build support for sexual and reproductive health services across diverse stakeholders.

Care needs to be taken, however, to ensure that the voices of all community members are heard. This requires efforts to ensure the inclusion and equal participation of men and women and those from poor or ethnic minority households. Where women are especially disempowered, they may be enabled to speak in focus group discussions held separately from those held with the men. Similarly, it may be better to seek the input of marginalized groups in a forum where powerful members of the community are not present. Box 27 discusses an initiative that used participatory methods to challenge gender norms among young male and female factory workers in Chiang Mai, - Thailand.

Box 26: Partnering with Buddhist monks and nuns to curb the HIV/AIDS epidemic in Cambodia

Most ethnic Cambodians are Theravada Buddhists. While the constitution of Cambodia protects religious freedom, Buddhism is the dominant religion. The Government promotes national Buddhist holidays and provides education, training and other support to monks. Close associations exist between Buddhism, Khmer cultural tradition and daily life in Cambodia. Buddhist traditions are widespread and dynamic in all provinces and have been enjoying a revival following the decades of civil war.

Buddhist monks and the *wat* (spiritual centre) are core components of Buddhism. Each village traditionally has a *wat*, which houses anywhere from five to 70 monks depending upon the local population. About 80% of monks join the monkhood temporarily; boys and young men join for a variety of reasons, ranging from the need for shelter and protection to seeking an education.

Monks occupy high moral status in Cambodian society and often wield great influence. Although monks are expected to remain politically neutral, many have become active in the fight against HIV/AIDS. The Supreme Patriarchs of the two monastic orders spoke of the urgent need to prevent the spread of HIV/AIDS in their discourses during the 1990s. The Supreme Patriarchs have also encouraged monks and nuns to provide services to their communities. Monks and nuns in many parts of the country have become advocates of reducing discrimination against people affected by HIV/AIDS. While monks rarely talk explicitly about sexual issues, they tend to preach precepts, such as value of abstaining from sexual harassment and the virtue of fidelity and chastity.

In response to the influence of Buddhist monks and nuns in Cambodia, UNFPA has sought to forge strategic partnerships to further efforts to curb the HIV/AIDS epidemic and achieve improved reproductive health. According to UNFPA, monks and nuns have been largely involved in four main types of activities: (1) preventing the spread of HIV/AIDS through information and education campaigns inside and outside monasteries; (2) providing care and support to people living with HIV and AIDS; (3) training other monks to handle young people with HIV/AIDS; and (4) eliminating the stigma of HIV/AIDS through preaching the teachings of the Buddha, emphasizing compassion and easing the burdens of those affected by the epidemic. Given the position of monks and nuns in Cambodian society, many other strategic entry points have been identified. For example, efforts to integrate information on HIV/AIDS, reproductive health and gender equality into the Buddhist educational system could reach a large number of boys and young men. Encouraging monks to speak with couples about reproductive health when blessing newly married couples could improve the knowledge of young men and women on reproductive health issues and the threat of HIV/AIDS.

Source: United Nations Population Fund 2004b.

Improving the quality of health services

In order for the health system to integrate sexual and reproductive health care, health service providers must have the capacity to offer a basic package of quality services and to refer clients to other service providers as necessary. For example, antenatal and maternal service providers

need to be able to care for, or refer, a woman who is HIV positive; health workers providing HIV treatment and care need to be able diagnose and treat other STIs.

Health service providers require knowledge and skills to provide a range of services to individuals with different needs and who may enter the health system through various points. For example,

Box 27: Using peer education to challenge gender norms among young male and female factory workers in Chiang Mai, Thailand

With rapid social change in many countries across the Region, women are increasingly engaging in non-traditional forms of employment. Many in Cambodia, China, the Philippines and Viet Nam, among other countries, are leaving their rural homes to work in electronics and garment factories. The demand for female labour in factories is high, and wages and working conditions are perceived as being better than that in other sectors. Women who migrate to urban areas are often far from parents, families and traditional social norms. This detachment can alter perceptions of acceptable male-female behaviour.

A study among young male and female factory workers in Chiang Mai City, Thailand, revealed that social norms in the city associate masculinity with sexual prowess and that men prefer women who are sexually inexperienced. Young men and women agree that it is the responsibility of the woman to prevent pregnancy. With regard to HIV and STI prevention, few men take precautions unless the woman is perceived to be infected, while fear of being perceived as socially undesirable often prevents young women from adopting preventive behaviour. In combination, these social norms may place young men and women at high risk of STIs, including HIV.

In response, a peer education programme was set up to explore how gender roles and social norms influenced sexual behaviour, attitudes, relationships and communication patterns. The initiative aimed to increase awareness among young factory workers (aged 15–25 years) who had never been married. Eighteen peer leaders were trained to facilitate small groups through a variety of activities, including reading comic books and romance novels.

An evaluation of the programme found that peer education increased awareness and reduced risky behaviour among participants. An increased proportion of respondents were able to identity challenges to adopting risk reducing behaviour, such as peer pressure and male promiscuity. Following peer education, 42.3% of participants said that it was acceptable for women to raise the issue of HIV with men, compared to 29.9% before the programme. An increasing number of participants also felt it was appropriate for women to carry condoms. This suggests that both men and women developed an awareness of gender norms and how they influence the practice of safe sex.

Source: Cash *et al.* 1997. In: Boender *et al.* 2004.

voluntary counselling and/or testing for HIV, family planning and RTIs/STIs should be equally accessible to a man who seeks treatment from a STI clinic and a woman who attends an antenatal clinic. Again, as noted above, these services can be housed in a single clinic or linked

through an effective referral system. However, when determining which services should be offered under one roof and which should be integrated through a referral system, the social norms and expectations of the target communities need to be considered to ensure that the system responds adequately to their needs. For example, adolescents may not be comfortable seeking care from a clinic that has traditionally offered only antenatal and maternal care. Similarly, women may not be willing to sit in a waiting room together with men. In these cases, it may be more effective to link these services together through referral networks rather than housing them in a single clinic.

Besides integrating sexual and reproductive health services, the health system needs to be sensitive to how men and women's sexual and reproductive health needs change throughout their lifecycle and to respond with an appropriate range of services. This comprehensive approach requires a different set of skills. It also demands that health providers have information on the health care previously received by a man or woman and the health outcomes. The integration of sexual and reproductive health services over time has crucial

Box 28: Enhancing the quality of care of reproductive health services in Bangladesh

A reproductive health initiative in Bangladesh was developed to deliver a comprehensive package of reproductive health services in urban and under-served areas, with a special emphasis on quality of care. The main lessons from this project are as follows:

Quality of care increases client satisfaction.
In Bangladesh, health providers have a reputation for mistreating clients. Traditionally, poor community members were hesitant to visit clean and well-decorated clinics, assuming that the services were not meant for them or would be too expensive. The Government tried to change this perception by introducing reproductive health service protocols and teaching service providers how to treat and communicate with clients. At the same time, clients were educated on the type of care they should expect. Clients were asked to rate the conduct of service providers during exit interviews; most expressed an increase in satisfaction. At the same time, clients were educated in the type of care they should expect.

If possible, adapt existing protocols and guidelines.
The availability of standard protocols and guidelines for clinical services, which were developed by the Government in collaboration with nongovernmental organizations, saved time and resources. In addition, the adaptation of existing protocols contributed to an internally coherent and homogenous approach to family planning and reproductive health services in Bangladesh.

The process of improving the quality of care is lengthy and should be uninterrupted.
Improving the quality of care is a labour-intensive process that requires time, effort and motivation. This holds particularly true for behavioural change, which is necessary if a better understanding of the client situation is to be achieved. Service providers need encouragement to see the value in using service protocols and giving time to communicate with clients. Close monitoring and supervision are required, as well as regular refresher training to sustain quality and to compensate for the dropout of service providers.

Quality of care increases client attendance.
Investing in the quality of care pays off in the end. Improvements in the management of clinics, service-delivery procedures, staff attitudes and behaviour towards clients, as well as cleanliness, led to a substantial increase in clients (between 19% and 48%, depending on the facility, within one year). For example, one of the project hospitals expanded their facilities from 10 beds to 35 beds, introduced blood bank services, and continued to offer reproductive health services, including family planning. As a result, the number of total services rendered increased from 23 861 in 2000 to 35 527 in 2001.

Source: EC/UNFPA 2002.

implications for health information systems, particularly continued maintenance of client records. Box 28 discusses a reproductive health initiative in Bangladesh, which aimed to deliver a comprehensive package of reproductive health services to poor communities.

The manner in which health providers interact with men and women is a core aspect of the overall quality of health services. In addition to the knowledge and skills required to provide a range of services for sexual and reproductive health, training and awareness-building at all levels of the health system are required to improve the sensitivity and responsiveness of health service providers to the needs of their clients. This is particularly true in the area of sexual and reproductive health because of its sensitive nature in many communities. For example, it is vital that health professionals be aware of and responsive to patients' feelings and concerns and do not belittle them. Demeaning treatment from health workers is a common complaint among women, which deters them from seeking care. In particular, efforts should be made to increase awareness, sensitivity and skills of health service providers

Box 29: Challenging service providers to explore their attitudes and values regarding post-abortion care in the Philippines

One approach that can improve the sensitivity and responsiveness of service providers to the needs of their men and women clients is for providers to explore and challenge their own values and attitudes. An example of this approach comes from the Philippines, where a programme to improve post-abortion care encouraged service providers to become self-reflective.

An initial situation analysis identified a number of weaknesses in post-abortion care in the Philippines. Post-abortion care clients rarely received routine counselling, referrals to family planning or other reproductive health services. Clients were treated poorly and punitive treatment was common.

In response, EngenderHealth, an international NGO, implemented a programme from 2001 to 2002 that aimed to improve the skills of health providers in post-abortion care. The Prevention and Management of Abortion Complications programme adopted a two-pronged approach. The first aspect consisted of a forum wherein participatory methods were used to enable service providers to explore their attitudes and values concerning post-abortion clients. The second aspect consisted of a technical working group made up of representatives from the Department of Health, academia, doctors, nursing and midwifery associations, NGOs and tertiary hospitals. This working group was tasked to formulate a national work plan for post abortion care.

The programme trained health providers in post-abortion care counselling, family planning counselling, infection prevention and clinical post-abortion skills. As a result, the attitudes of health staff towards post-abortion clinics were found to change significantly; health service providers sought to improve both their behaviour and practice. Providers were more sensitive to and aware of the needs of their clinics. This encouraged them to treat their clients with dignity and respect. Preserving confidentiality and privacy during procedures and counselling became paramount.

Source: EngenderHealth 2003. In: United Nations Population Fund 2004b.

in dealing with marginalized communities, such as ethnic minorities and migrant communities, to ensure that all clients, especially those who are poor, are treated with dignity and respect. For example, in the city of Chengdu, China, the Gay Men's Community Care Organisation works with doctors in local STI clinics to ensure that men who have sex with men are treated with respect and dignity and that their needs are understood.

Health service providers need to be trained to deal with men and women patients as both clients and partners of other clients. This approach, coupled with an understanding of gender issues and communication and power dynamics in sexual relations between partners, can inform effective counselling and interventions with couples. It can also help ensure that women's rights and safety are maintained. Box 29 discusses one approach that has been used to improve the awareness and sensitivity of health service providers to the needs of their clients.

Sensitivity to the needs of individuals and communities extends beyond the interaction between clients and providers into to the space where health services are offered. For example, efforts to incorporate services for unmarried women, adolescents and men into health centres that have traditionally catered to married women, such as maternal and antenatal clinics, often require innovative strategies to ensure responsiveness to the specific needs of each of these groups. Catering to a variety of groups may require separate entrances and waiting rooms or different hours of service to create a sense of privacy and confidentiality. In some cases, separate youth-friendly services may be required (see Box 30). Box 31 describes how to make sexual and reproductive health services "male friendly."

Improving health communication and awareness

Advocacy or health communication strategies are often used in sexual and reproductive health

Box 30: Strategies to create youth-friendly services

Young people can face many barriers when seeking to access sexual and reproductive health services. Experience shows that, to make services more accessible to young people, the following strategies can be adopted.

Service providers:

- Have specially trained staff.
- Show respect for young people.
- Honour privacy and confidentiality.
- Devote adequate time for client–provider interaction.
- Make peer counsellors available.

Health facilities:

- Set aside separate space or special times.
- Ensure convenient hours and location.
- Provide adequate space and sufficient privacy.
- Have comfortable surroundings.

Program design:

- Involve youth in design, service outreach and delivery, and continuing feedback.
- Welcome drop-in clients or arrange their appointments rapidly.
- Reduce overcrowding and waiting times.
- Ensure affordable fees.
- Adopt publicity and recruitment that inform and reassure youth.
- Welcome and serve boys and young men.
- Make a wide range of services available.
- Make necessary referrals available.

Other possible characteristics:

- Ensure availability of educational material.
- Make group discussions available.
- Set timing of pelvic examination and blood tests to meet needs.
- Provide alternative ways to access information, counselling and services.

Source: United Nations Population Fund 2003.

programmes to communicate information strategically, with the aim of changing the perceptions and influencing the decisionmaking of individuals. Indeed, interventions that encourage the adoption of risk-reducing practices and actions remain a core aspect of sexual and reproductive health promotion. Education and raising awareness are key to improving the health of populations, communities and individuals. Providing information on preventive practices, such as family planning and condom use, and the signs and symptoms of STIs and maternal health, can enable people to make decisions that positively influence their sexual and

reproductive health. Health communication strategies typically focus on creating change at the level of individual or household. With regard to sexual and reproductive health, experience has shown that such strategies

Box 31: Strategies to create male-friendly services

Experience shows that a number of strategies can contribute to creating sexual and reproductive health services that are responsive to men.

- Use a name for the programme and/or facility that welcomes men and women.
- Decorate the facility in a way that appeals to men and women.
- Designate a male restroom.
- In waiting areas, include reading materials that interest men.
- Make information, education and communication materials readily available to men.
- Make condoms easily available.
- Create an individual medical chart for each man, rather than keeping his medical information in his woman partner's file.
- Provide facility space and time for seeing couples so that men and women can receive counselling together, if desired.
- Create awareness of men's reproductive health in the community. Advertise the availability of men's reproductive health services.
- Adapt clinic hours to meet men's needs.

Source: United Nations Population Fund n.d.

are unlikely to lead to sustained changes in behaviour and perceptions. This is because these approaches may fail to recognize the influence that broad sociocultural elements can have on individuals. To be effective, these strategies need to target the individual and aim to create an environment that supports the advocated social or behavioural change. For example, to promote safe sexual practices, a health communication campaign can be combined with counselling and training on safe sex negotiation among young men and women. A wider advocacy campaign could then address the social norms that work against the adoption of safe sex practices.

Health communication strategies also need to be tailored to the specific characteristics and needs of the intended population group. For example, school-based sex education has been found to improve the knowledge of risk-reduction strategies among youth. Targeting communication strategies to in-school youth, the military, women and farmers, among other groups, requires collaboration between various ministries, including health, education, defence women's affairs and agriculture. The ministry of health should play a leading role in formulating and providing appropriate educational materials. It should also establish and maintain the relationships with other government ministries that are required to implement effective sexual education programmes for multiple groups.

Such health communication materials need to be developed to pique the users' interest and meet their needs. For example, UNFPA explains how HIV- and STI-related materials need to be developed from a men's perspective and that materials that address issues of pleasure, power and security have been found to be particularly effective.388 Often, community members are a means of disseminating information, as they are trusted and well-versed in the local situation. - is approach was harnessed to advocate for vasectomies among men in Kiribati (Box 32).

Health communication and advocacy initiatives that target the general population may not reach poor households because of generally lower levels of education and lower access to modes of communication, such as television and radio. Numerous factors, including distance, cultural and linguistic barriers, may prevent health communication messages from reaching ethnic minority communities. Communication strategies and messages, therefore, must be tailored to these groups, such as through illustrated messages for those with low literacy levels. When targeting minority groups, culturally appropriate messages delivered in local languages are required. Outreach strategies may likewise be undertaken by health staff or community-based health workers to increase knowledge and

Box 32: Satisfied men as advocates and community-based promoters for vasectomies in Kiribati

UNFPA supported a vasectomy project in Kiribati to improve the health of men and women and to enhance male involvement in family planning. The project enlisted the support of men from the target communities who were satisfied with their vasectomies to disseminate information and to encourage men to consider the procedure (instead of female modes of family planning). These men promoted family planning and worked as health personnel. Their advocacy was based on their personal experience, which testified to the simplicity, safety and effectiveness of the method. Mobile family planning teams offered a range of family planning services, including vasectomy, to all outer islands and rural areas.

The efforts of the community advocates were supplemented with health communication materials (pamphlets, posters, videos and calendars). Primary health staff further encouraged men who had had vasectomies to share their experiences in peer meetings, seminars, radio and video programmes and through one-to-one communication. As a result, the number of men who have had vasectomies is greater than the number of sterilized women.

Source: UNFPA Country Support Team in Fiji. In: United Nations Population Fund n.d.

awareness among hard-to-reach groups and low-income settings.

Women may be similarly hard to reach through conventional health promotion campaigns because of lower levels of literacy than men and gender norms that may restrict women's access to mainstream media. Because women tend to gather health-related information from relatives and social networks, interpersonal modes of communication may be more effective than print media, for example. Involving poor individuals and women in the design and implementation of health communication campaigns can ensure that local knowledge, priorities and needs are understood and subsequently addressed. These strategies may likewise ensure that the message and medium of health promotion campaigns are accessible for women.

Young people who have access to accurate information and the opportunity to discuss sexual and reproductive health issues have been found to change their behaviour to reduce their risk of disease. Responsibility for providing adolescents with the information they need to protect their sexual and reproductive health lies with parents and teachers, with the support of the wider community. Peer counselling and other means of involving informed youth in educating other young people have also been found to be successful.

Age-appropriate sexual and reproductive health information can empower youth to make responsible decisions. Some examples of these approaches are as follows:

- Youth Zone Project in the Philippines provides a safe space for young people to learn about HIV/AIDS through a variety of innovative strategies. It provides services, including medical care, to around 20–25 young people each day, particularly vulnerable groups.
- Peer education was used to promote negotiation skills and safe sex practices among women working in bars in the Lao People's Democratic Republic and Cambodia. Women working in bars tend to engage in casual commercial sex but do not necessarily identify themselves as sex workers.

Monitoring and evaluation and research

Despite the growing recognition of ongoing and often increasing health inequities both in developing and developed countries, health information systems have, to date, been weak in yielding information needed to assess and address health inequities. The challenges are to determine the information needs for addressing health inequities; to shape health information systems to meet those needs; to promote sensitization to equity issues; and to develop the skills required to use information for effective planning and policy-making.

The Health Metrics Network has begun work on the construction of equity indicators and on creating mechanisms to link records between data sources. Complementary measures to the global Health Metrics Network for sexual and reproductive health can be undertaken at the country level.

At the national level, disaggregated data are required to assess and analyse the extent of inequalities in the determinants of sexual and reproductive ill-health and related morbidity and mortality, as well as to monitor changes in these patterns over time. Likewise, disaggregated data are required to identify priority areas and interventions that will benefit poor individuals and how interventions may differently affect men as compared to women. Table 11 presents an example applying a human rights-based approach to health indicators to the reproductive health strategy endorsed by the World Health Assembly in May 2004.

Data collected routinely within the health system should be disaggregated and analysed by socioeconomic status, gender, urban-rural location, by region or province, by level of educational, occupation, or other indicators of disadvantages identified through a poverty analysis.

Monitoring and evaluation also should consider these variables. These efforts can be supplemented with appropriate research, including qualitative data to assess unmet needs, perceived quality of health care services, and various financial and non-financial barriers that poor men and women may face when accessing sexual and reproductive health services.

Table 11: Right to health indicators: applying a human rights-based approach to WHO's reproductive health strategy, 2004

	Structural indicators	
Basic legal context	S1. Has the State ratified the following international treaties recognizing the right to health: a. ICESCR? *yes/no.* b. CRC? *yes/no.* c. CEDAW? *yes/no.* d. ICERD? *yes/no.* S2. Does the State's constitution include the right to health? *yes/no.* S3. Does State legislation expressly recognize the right to health, including sexual and reproductive health rights? *yes/no.*	
Basic financial context	S4. Does the State have a law to ensure *universal access* to sexual and reproductive health care? *yes/no.*	
National strategy and plan of action	S5. Does the State have a national sexual and reproductive health strategy and plan of action? *yes/no.* S6. Does the strategy and plan of action provide for *universal access* to sexual and reproductive health care? *yes/no.* S7. Does the strategy and plan of action: a. expressly recognize sexual and reproductive health rights? *yes/no.* b. clearly identify: i. objectives? *yes/no.* ii. time frames? *yes/no.* iii. duty holders and their responsibilities? *yes/no.* iv. reporting procedures? *yes/no.* c. specifically include measures to benefit vulnerable groups? *yes/no.*	
Participation	S8. Does the strategy and plan of action establish a procedure for the State to regularly consult with a wide range of representatives of the following groups when formulating, implementing and monitoring sexual and reproductive health policy: a. nongovernmental organizations? *yes/no.* b. health professional organizations? *yes/no.* c. local governments? *yes/no.* d. community leaders? *yes/no.* e. vulnerable groups? *yes/no.* f. private sector? *yes/no.*	
Information	S9. Does State law protect the right to seek, receive and impart information on sexual and reproductive health? *yes/no.* S10. Does the State have a strategy and plan of action to disseminate information on sexual and reproductive health to the public? *yes/no.* S11. Does the strategy and plan of action establish a procedure for the State to regularly disseminate information on its sexual and reproductive health policies to: a. nongovernmental organizations? *yes/no.* b. health professional organizations? *yes/no.* c. local governments? *yes/no.* d. media accessible in rural areas? *yes/no.* S12. Does State law protect the confidentiality of personal health information? S13. Does State law require informed consent of the individual to accept or refuse treatment?	

	Process indicators	Outcome indicators
	P1. Number of reports the State has submitted to the treaty-based bodies monitoring the following treaties: a. ICESCR b. CRC c. CEDAW d. ICERD P2. Number of national judicial decisions that considered sexual and reproductive health rights in the last five years	
	P3. Percentage of government budget allocated to health P4. Percentage of government *health budget* allocated to sexual and reproductive health P5. Percentage of government *health expenditure* directed to sexual and reproductive health P6. Per capita *expenditure* on sexual and reproductive health	
	P7. Does the State collect data adequate to evaluate performance under the strategy and plan of action, particularly in relation to vulnerable groups? *yes/no.*	
	P8. Does the State regularly consult with a wide range of representatives of the following groups when formulating, implementing and monitoring sexual and reproductive health policy: a. nongovernmental organizations? *yes/no.* b. health professional organizations? *yes/no.* c. local governments? *yes/no.* d. community leaders? *yes/no.* e. vulnerable groups? *yes/no.* f. private sector? *yes/no.*	
	P9. Percentage of people exposed to information on: a. maternal and newborn care b. family planning services c. abortion and post-abortion care d. prevention and treatment of sexually transmitted infections e. prevention and treatment of cervical cancer and other gynaecological morbidities P10. Does the State regularly disseminate information on its sexual and reproductive health policies to: a. nongovernmental organizations? *yes/no.* b. health professional organizations? *yes/no.* c. local governments? *yes/no.*	O1. Percentage of women who know about contraceptive methods traditional or modern. *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.* O2. Percentage of people 15–24 years old who know how to prevent HIV infection *disaggregated at least by sex, race, ethnicity, socioeconomic status and rural/urban.* O3. Percentage of people who believe that personal information disclosed to health professionals remains confidential *disaggregated at least by age, sex, race, ethnicity, socioeconomic status and rural/urban.*

Continued on next page

Table 11 (continued)

	Structural indicators	
National human rights institutions	S14. Does the State have a national human rights institution with a mandate that includes sexual and reproductive health rights? *yes/no.*	
International assistance and cooperation these indicators are for donors.	S15. Is the State's overseas development assistance policy rights-based? *yes/no.* S16. Does the State's overseas development policy include specific provisions to promote and protect sexual and reproductive health rights? *yes/no.*	
Priority Aspect 1: Improving antenatal, delivery, post-partum and newborn care	S17. Does the State have a strategy and plan of action: a. to reduce maternal deaths and their causes? *yes/no.* b. to ensure a universal system of referral for obstetric emergencies? *yes/no.* c. for access to care, treatment and support for HIV-infected pregnant women? *yes/no.*	
Priority Aspect 2: Delivering high-quality services for family planning	S18. Does State law: a. require third-party authorization for women to receive family planning services? *yes/no.* b. specify that only married women may receive family planning services? *yes/no.* S19. Does the national essential medicines list include: a. condoms? *yes/no.* b. hormonal contraceptives, including emergency contraceptives? *yes/no.*	

Process indicators	Outcome indicators
d. media accessible in rural areas? *yes/no*. P11. Percentage of health facilities with protocols on the confidentiality of personal health information P12. Percentage of health professionals who have received training on: a. the confidentiality of personal health information b. the requirement of informed consent to accept or refuse treatment	
P13. Number of the following activities the institution has run on sexual and reproductive health rights in the last five years: a. training programmes b. public campaigns P14. Number of complaints concerning sexual and reproductive health rights the institution has considered in the last five years	
P15. Percentage of overseas development assistance directed to sexual and reproductive health P16. Do the State's reports to the human rights treaty-based bodies include a detailed account of the international assistance and cooperation it is providing, including in relation to sexual and reproductive health? *yes/no/not applicable*. P17. Does the State provide a country-specific annual report of its international assistance and cooperation, including in relation to sexual and reproductive health: a. to the government of the recipient country? *yes/no*. b. to the public of the recipient country? *yes/no*.	
P18. Number of facilities per 500 000 population providing: a. basic obstetric care b. comprehensive obstetric care P19. Percentage of births attended by skilled health personnel* *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.* P20. Percentage of pregnant women counselled and tested for HIV/AIDS *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.* P21. Percentage of pregnant women screened for syphilis *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.*	O4. Percentage of women with *access* to antenatal, delivery, post-partum and newborn care *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.* O5. Maternal mortality ratio number of maternal deaths per 100 000 live births.* *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.* O6. HIV prevalence among pregnant women who are 15–24 years old* *disaggregated at least by race, ethnicity, socioeconomic status and rural/urban.* O7. Syphilis prevalence among pregnant women who are 15–24 years old *disaggregated at least by race, ethnicity, socioeconomic status and rural/urban.* O8. Neonatal mortality rate number of infant deaths within one month of birth per 1000 live births. *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.*
P22. Percentage of primary health care facilities providing comprehensive family planning services full range of contraceptive information, counselling and supplies for at least six methods, including male and female, temporary, permanent and emergency contraception.	O9. Percentage of people with *access* to comprehensive family planning services *disaggregated at least by age, sex, race, ethnicity, socioeconomic status and rural/urban.* O10. Percentage of women at risk of pregnancy who are using or whose partner is using, a contraceptive

Continued on next page

Table 11 (continued)

	Structural indicators	
Priority Aspect 3: Eliminating unsafe abortion	S20. Does State law allow abortion: a. on request? *yes/no.* b. for economic or social reasons? *yes/no.* c. for the physical and/or mental health of the woman? *yes/no.* d. to save the life of the woman? *yes/no.* e. for cases of rape or incest? *yes/no.* f. for foetal impairment? *yes/no.* g. in no circumstances? *yes/no.* S21. Does State law criminalize abortion? *yes/no.* S22. Does the State have a strategy and plan of action to: a. prevent unsafe abortion? *yes/no.* b. provide post-abortion care? *yes/no.*	
Priority Aspect 4: Combating sexually transmitted infections, cervical cancer and other gynaecological morbidities	S23. Does the State have a strategy and/or plan of action: a. to prevent sexually transmitted infections, including HIV? *yes/no.* b. to treat sexually transmitted infections? *yes/no.* c. to make antiretroviral treatment available for people living with HIV? *yes/no.* d. to prevent cervical cancer? *yes/no.*	
Priority Aspect 5: Promoting sexual health including for adolescents	S24. Does State law require comprehensive sexual health education during the compulsory school years? *yes/no.* S25. Does the State have a strategy and/or plan of action to promote adolescent sexual and reproductive health? *yes/no.* S26. Does State law prohibit sexual violence, including marital rape? *yes/no.* S27. Does State law prohibit female genital mutilation and other harmful traditional practices? *yes/no.* S28. Does State law prohibit marriage for both men and women prior to age 18? *yes/no.* S29. Does State law require full and free consent of the parties to a marriage? *yes/no.*	

CEDAW = Convention on the Elimination of All Forms of Discrimination Against Women; CRC = United Nations Convention on the Rights of the Child; ICERD = International Convention on the Elimination of All Forms of Racial Discrimination; ICESCR = International Covenant on Economic, Social and Cultural Rights

* Indicates a Millennium Development Goal indicator

Note: This illustration was developed by Prof Paul Hunt, the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, in his report to the Sixty-second session of the Commission on Human Rights in March 2006.

Process indicators	Outcome indicators
	method all methods.* *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.*
	O11. Percentage of women at risk of pregnancy who desire to avoid pregnancy, but who are not using and whose partner is not using, a contraceptive method *disaggregated at least by age race, ethnicity socioeconomic status and rural/urban.*
P23. Percentage of service delivery points providing abortion and/or post-abortion care P24. Percentage of practitioners trained in abortion and/or post-abortion care	O12. Percentage of women with access to abortion and/or post-abortion care *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.* O13. Abortion rate number of abortions per 1000 women of reproductive age. *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/ urban.* O14. Percentage of maternal deaths attributed to unsafe abortion *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.*
P25. Number of condoms available for distribution nationwide during the preceding 12 months, per population aged 15–49 years P26. Percentage of family planning service delivery points offering counselling on dual protection from sexually transmitted infections including HIV and unwanted pregnancies P27. Percentage of women screened for cervical cancer within the past five years *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.*	O15. Percentage of people with access to: a. health care for sexually transmitted infections b. preventative care for cervical cancer and other gynaecological morbidities *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/ urban.* O16. Percentage of people with self-reported or diagnosed symptoms of sexually transmitted infections, classified by condition *disaggregated at least by age, sex, race, ethnicity, socioeconomic status and rural/urban.* O17. HIV prevalence in subpopulations with high-risk behaviour *disaggregated at least by age, sex, race, ethnicity, socioeconomic status and rural/urban.* O18. Percentage of women with cervical cancer *disaggregated at least by age, race, ethnicity, socioeconomic status and rural/urban.*
P28. Percentage of people 15–19 years old who have received comprehensive sexual health education in school *disaggregated at least by sex, race, ethnicity, socioeconomic status and rural/urban* P29. Number of incidents of sexual violence, including marital rape, reported to law enforcement and/or health professionals in the past five years	O19. Percentage of 15–19 year olds who know how to prevent HIV infection O20. Age-specific fertility rate 15–19 and 20–24 year olds. *disaggregated at least by race, ethnicity socioeconomic status and rural/urban.* O21. Age at marriage *disaggregated at least by sex, race, ethnicity, socioeconomic status and rural/urban.* O22. Percentage of women who have undergone female genital mutilation – *disaggregated at least by sex, race, ethnicity, socioeconomic status and rural/urban.*