

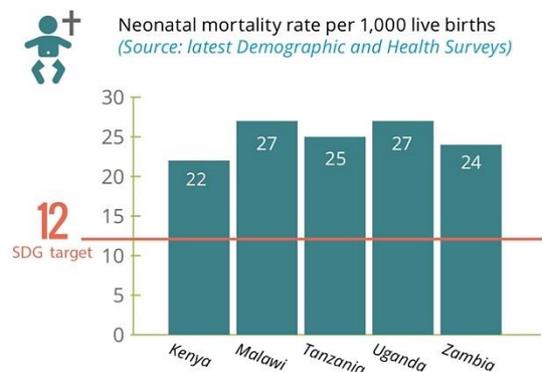
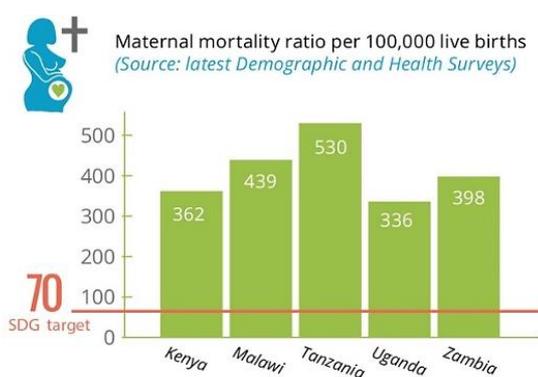
A STRONG HEALTH SYSTEM IS A PREREQUISITE FOR SEXUAL & REPRODUCTIVE HEALTH AND RIGHTS

The attainment of sexual and reproductive health and rights (SRHR) is a key component in sustainable development. It clearly links to gender equality and women’s empowerment by providing bodily autonomy and choices around sexuality and reproduction. The attainment of SRHR requires a multisectoral effort, involving schools, communities, workspaces and many more. However, the most critical prerequisite for SRHR is a responsive, strong and well-functioning health system, that is properly staffed and financed.

WHAT ARE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS?

SRHR are fundamental to good health and the well-being of every population and crucial to gender equity and equality. They are basic human rights that should be respected, protected and fulfilled both in and outside the health system. Importantly, access to affordable and quality sexual and reproductive health (SRH) services are pivotal to meet specific health needs of women and girls throughout their lifespan; these services have a strong impact on the full range of Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH). Additionally, access to SRH services can empower women to be economically independent and pursue careers based upon their own preferences.

Up until today, **214 million women** in developing countries do not use modern contraceptive methods. In Africa, **24.2%** of women of reproductive age have an unmet need for family planningⁱ. Maternal mortality, although it has declined, is still **546 per 100,000 live births** in sub-Saharan Africaⁱⁱ. Countries have not yet been able to fully integrate and facilitate access to these services and rights, even though they are an indispensable component of the countries’ way towards universal health coverage (UHC).



To define the components of SRHR we use the framework proposed in the Lancet in 2018 by Starrs et al.ⁱⁱⁱ According to this definition, SRH services should include the following:

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

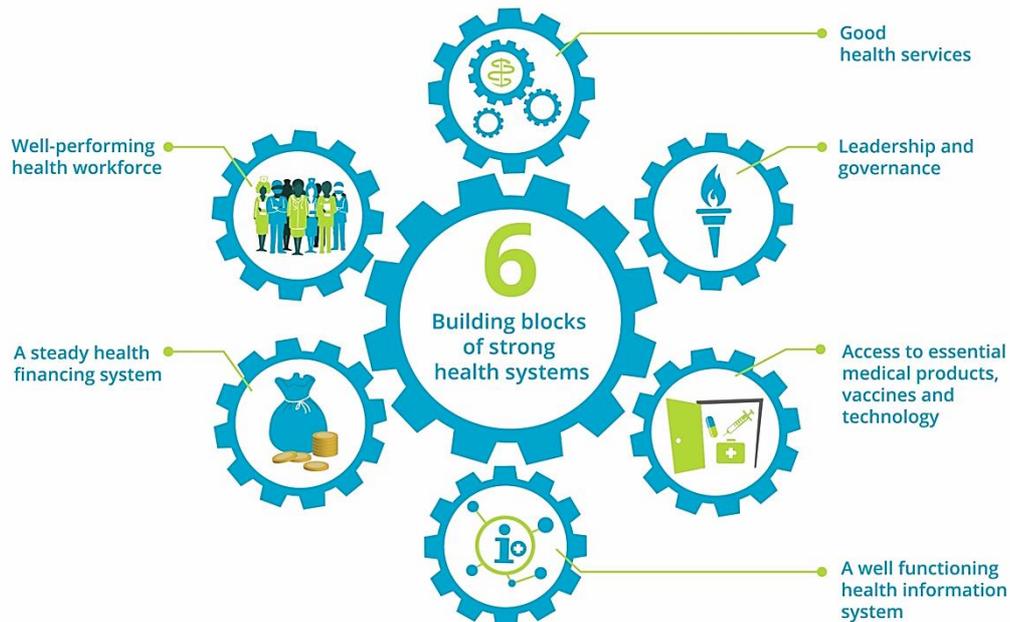
To achieve the highest attainable standard of SRH, the attainment of sexual and reproductive rights (SRR) precedes. This means people should be able to:

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



SRHR AND HEALTH SYSTEMS STRENGTHENING

The framework that the World Health Organization (WHO) uses to describe health systems consists of six building blocks^{iv}, as shown in the illustration below. All these building blocks need to be in place for a health system to work effectively.



In this paper we will focus on the building blocks on the left side; a steady health financing system and a well-performing health workforce. Even though the linkages between these two building blocks and the attainment of SRHR are not always explicit, they are a prerequisite to better SRHR outcomes, and actually apparent and straightforward when you take a closer look.

HEALTH FINANCING

Sufficient, equitable, reliable and effectively channelled health financing can support and enable the attainment of SRHR. Out-of-pocket payments have been a reason for women to forgo health care, including maternal and neonatal health care, which results in higher neonatal, infant and maternal mortality. In severe cases, women have also been imprisoned at hospitals after labour because of their inability to pay the hospital bills^v.

Women in low- and middle-income countries tend to have less ownership of their family's financial means^{vi}. Therefore, it is particularly important to take a gendered perspective in the design of health financing schemes. For example, insurance schemes focused at the formal sector are less likely to cover women, who mostly work in the informal sector. This could be

solved by including the rest of the family in a scheme by default or by creating a progressively public-funded system accessible to all, despite insurance coverage.

For SRHR specifically, political choices on the allocation of funds can determine whether people have access to services. Health financing can provide the quality services necessary to ensure a safe and healthy pregnancy and childbirth, and healthy infants. In addition, taking family planning into account, funds can allow sufficient supply of affordable, effective and acceptable methods of contraception, as well as the inclusion of contraception in the basic healthcare package (independent of age and marital status), so they are free to access or reimbursable. Moreover, they can allow screening and provide treatment for sexually transmitted infections (STIs) including HIV, preventing and managing cancers of the reproductive system, and safe abortion and post-abortion services.



“I am eager to help people in Malawi who are lacking, especially in the rural areas, because they cannot access health care. However, resources are very limited. It takes a long time to receive materials. Sometimes we don’t even have gloves to monitor pregnant women!”

Brighton, nurse midwife technician, Ngokwe health Centre, Malawi

Beyond the SRH direct clinical services, health financing can be extended to provide evidence-based comprehensive sexual and reproductive education to adolescents aiming to shape empowered, respectful, responsible and self-determined citizens, sexually active or not. Such education and awareness-raising does not have to be limited to schools. It can extend to the training of health professionals, so they can provide accurate and un-stigmatising counselling on SRHR, especially when it comes to abortion and post-abortion care, which is still a controversial issue in many countries and social settings.

Health financing also contributes to the development of human resources for health, which brings us to the next health system building block; the health workforce.

HEALTH WORKFORCE

In the era of the Sustainable Development Goals (SDGs) and UHC, the topic of human resources for health is undoubtedly relevant. It is a tool to realise these global targets, as expressed, among others, by the WHO and the Global Health Workforce Alliance (GHWA), who claim that *“there is no health without a workforce”* ^{vii}. Even if there has been a debate on the understanding of UHC, it is agreed that an essential part of its attainment is the governance, management, performance and productivity of the health workforce through a holistic approach. Despite human resources for health being part of a chain which also

includes infrastructure, equipment, medicines, consumables and financial resources, “at the simplest level, without health workers, there can be no health services”.^{v (p.11)}

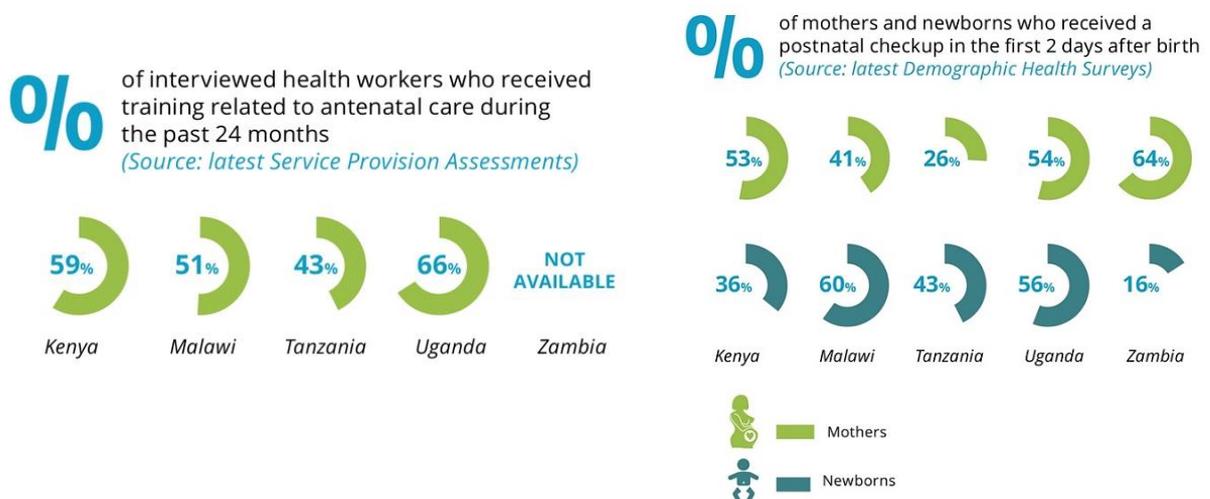
A fit-for-purpose, educated, motivated and supported health workforce can support and facilitate the attainment of SRHR, through various pathways. Health professionals are the ones to provide services and counselling for safe pregnancies and deliveries, safe abortion and post-abortion care, as well as prevention and treatment for STIs (including HIV), cancers of the reproductive system, and sexual and reproductive disorders. The provision of health care is related to the availability of skilled health workers. Nevertheless, the big shortage hampers access to receive such care.



“The critical challenge all over the world is the shortage of nurses; there are not enough, and they are tired. In the nursery there are only two nurses. During the night shift there is only one nurse. But the sick babies need attention. And the same nurses who are taking care of the sick babies, are also taking care of the premature babies. This means there cannot be quality care.”

Annie, nurse Balaka district hospital, Malawi

The provision and accessibility of family planning do not necessarily require specialist health care. Community health workers are often appointed as a solution to increase access to family planning, specifically in rural areas, and have been positively associated with the uptake of modern family planning in low- and middle-income countries. However, in Africa, only 7% of the community health workers receive a stipend, and even less a decent living wage for the work they provide. Sometimes work that can be emotionally and physically demanding is even shifted from qualified nurses to community health workers. Therefore, decent working conditions are required for the services of community health workers.



Lastly, while health workers hold a key role in SRHR, access also depends on their values. Especially SRR can be hampered when health workers have cultural or religious oppositions, for example in relation to the use of contraceptives by unmarried women, the requirement of parental consent, stigmatisation of STIs, or stigma against men having sex with men. Therefore, it is important that SRHR are part and parcel of the education of health workers, including community health workers.

SRHR REQUIRE STRONG HEALTH SYSTEMS

The link between a strong health system and the attainment of SRHR is cross-cutting and can be found in all of the six building blocks of a health system. From this short analysis, we reaffirm the vital contribution of effective health financing and strong health workforce to achieve SRHR for all. That's why, at Wemos, we keep advocating for improvement of health systems all over the world.

Want to read more?

Have a look at this additional information:

- Country report Uganda: [Health workforce financing in Uganda: Challenges and opportunities \(full report\)](#)
- Advocacy brief: [Uganda's human resources for health: paradoxes and dilemmas](#)
- Country report Malawi: [Mind the funding gap: who is paying for the health workers?](#)
- Fact sheet: [Fiscal space and four ways to increase it](#)
- Factsheet: [Public finance targets for UHC](#)

Graphs and photos

- Graphs on pages 1 and 5 are part of the Wemos infographic [Financing for Health \(SDG3\): Shared global responsibility – an analysis of five African countries](#)
- The graph on page 3 is part of the Wemos infographic [Health systems, what are they?](#)
- Photo on page 2 by Reproductive Health Supplies Coalition on Unsplash
- Other photos by Wemos

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- ⁱⁱⁱ Starrs AM, Ezeh AC, Barker G, Basu A, Bertrand JT, Blum R, et al. *Accelerate progress—sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission*. *Lancet* [Internet]. 2018;391(10140):2642–92. Available at: <https://linkinghub.elsevier.com/retrieve/pii/S0140673618302939>
- ^{iv} World Health Organization. *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies* [Internet]. WHO Publications, Geneva, 2010. Available from: https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf
- ^v Yates R, Brookes T, Whitaker E. *Hospital Detentions for Non-Payment of Fees: A Denial of Rights and Dignity*. Chatham House Cent Glob Heal Secur, December 2017.
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