GLOBAL HEALTH NEEDS

SEXUAL REPRODUCTIVE HEALTH AND RIGHTS

Why governments must guarantee equitable access to sexual and reproductive health services and rights

Save the Children

CONTENTS

1. INTRODUCTION

Everyone has the right to good sexual and reproductive health (SRH). Lack of SRH services seriously impacts women, men and adolescents and the realisation of their sexual and reproductive health and rights (SRHR). SRH is critical to preventing sexually transmitted diseases, maternal mortality, and gender-based violence. Access to SRH services gives women the opportunity to choose whether and when, to have children. Lack of access to SRH services impedes the right of women and girls. For example, unintended pregnancies often lead to girls being taken out of school, and adolescent pregnancy is a key driver of child marriage. When poor families must pay out of pocket for SRH services they become at risk of catastrophic payments which can drive them deeper into poverty.

According to the Guttmacher Institute, a research and policy organization committed to advancing sexual and reproductive health and rights (SRHR) worldwide, in 2019 there were 218 million women in lower- and middle-income countries who did not have access to a modern form of contraception. This led to 111 million unintended pregnancies and 35 million unsafe abortions. 16 million women and 13 million newborns did not receive care for complications related to pregnancy and childbirth. The deaths of 2.5 million infants could have been prevented with proper access to health services including SRH.[1]

Globally, governments must do better at ensuring everyone, including women and adolescent girls, realizes their rights to SRH. Without urgent action, progress on improving women's and girls' lives globally will be further stalled. It will also undermine the global community's ability to continue to make progress on other goals, such as ending preventable child and maternal deaths and ending child marriage.

DEFINING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

In 2018, the Guttmacher–Lancet Commission offered a comprehensive definition of SRHR, and proposed an essential package of SRH interventions.[2] This includes the commonly recognized components of SRH, including contraceptive services, maternal, and newborn care, and prevention and treatment of HIV and AIDS. It also includes less commonly provided interventions that are necessary for a holistic approach: care for sexually transmitted infections (STIs); comprehensive sexuality education (CSE); safe abortion services (SAS); prevention, detection, and counselling for gender-based violence (GBV); prevention, detection and treatment of infertility and cervical cancer; and counselling and care for sexual health and well-being.

2. SEXUAL AND REPRODUCTIVE HEALTH: HUMAN RIGHTS AND SHARED GLOBAL GOALS

Human rights

The right to health is a fundamental right of all individuals, and SRH is inextricably linked to multiple human rights that are recognized in international agreements such as the Universal Declaration of Human Rights (1948), the Convention on the Rights of the Child (UNCRC, 1990) and the Convention on the Elimination of All Forms of Discrimination Against Women (1979).

In line with these instruments, governments must strengthen women's and girls' as well as men's and boys' access to quality SRH services and ensure their right to decide over their bodies and their sexuality. They must effectively address gaps and violations to these rights.

> ***"Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals".***
>
> The Guttmacher-Lancet Commission

Shared global goals

In 2015, all 193 UN member states adopted the 2030 Agenda for Sustainable Development, including 17 Sustainable Development Goals (SDGs).[3] In doing so, states made a specific commitment to achieving universal access to SRH services (Goal 3) and gender equality (Goal 5).

The 17 SDGs are defined in 169 Targets, many of which cannot be achieved without addressing the SRHR of women and adolescent girls.
These include:

- **SDG Target 3.7.** By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.
- **SDG Target 3.8.** Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.
- **SDG Target 5.3.** Eliminate all harmful practices, such as child, early and forced marriage and female genital cutting.
- **SDG Target 5.6.** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

SRH is an integral part of universal health coverage (UHC), the subject of SDG Target 3.8.4 UHC includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. Universal SRH services cannot be achieved without progress towards UHC. Both require a well-functioning healthcare system with adequate human and financial resources. Countries moving towards UHC need to consider how the SRHR needs of their population are met, from infancy all the way through to old age.

Sexual and reproductive health services are essential to meeting wider targets

Advancing SRHR, and providing rights-based services, are essential for progress in gender equality, women's and girls' empowerment and rights, economic development, education, nutrition, newborn survival and health, and child protection, including preventing GBV.

SRHR is vital to achieving SDGs on education, economic participation, and gender equality. Violations of SRHR such as inadequate provisions for menstrual hygiene management and violations related to child marriage and female genital cutting (FGC) negatively affect girls' school attendance and educational attainment. Low educational status also hinders access to SRHR, creating a vicious cycle of ill health. Child marriage and early motherhood often end a girl's school attendance while data shows that each additional year a girl accesses education increases her employment prospects and future income potential.[5] Whether a woman or girl can access SRHR, is therefore closely linked to her economic participation, which has economic benefits for individuals, families, communities, and wider society.

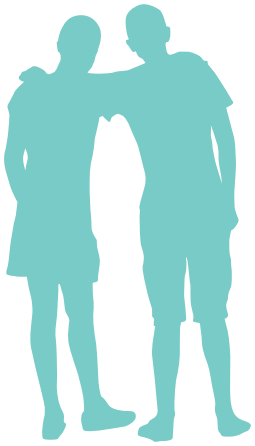
Integration of SRH services such as family planning into other sector programming is critical. According to the UN, family planning and other interventions, such as CSE programs, can have a significant impact on improving people's nutritional status. Birth spacing, for example, allows women's bodies to recuperate and replenish essential nutrients, so their infants are better nourished, thereby reducing the prevalence of chronic ill-health resulting from malnutrition. Integrating and strengthening family planning services into nutrition or food security programming can both increase access to family planning services and improve nutrition outcomes.[6]

3. WHY ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IS CRITICAL

Equality of access to SRHR, information and services varies across the globe.[7] Before the COVID-19 pandemic there were already gaps in access to SRH services. Women, adolescent girls and boys, and those most subject to inequality and discrimination, such as people living with disabilities, populations affected by conflict and disaster including the climate crisis, and people with diverse sexual orientations, gender identities and expressions, and sex characteristics, were among those most affected by these gaps.

Worldwide, each year:[8]

35 MILLION
unsafe abortions take place



over
350 MILLION
women and men need treatment for one of the four curable STIs

there are nearly
2 MILLION
new HIV infections, 150,000 of which are among adolescents

approximately
266,000
women die from cervical cancer.

Lack of access to comprehensive SRH services heightens the risk of unsafe abortions and increases maternal mortality. 45% of all abortions are unsafe; 97% of unsafe abortions take place in developing countries. Unsafe abortion is a leading cause of maternal death globally, accounting for an estimated 4.7% to 13.2% of maternal deaths annually.[9] Meanwhile, 650 million girls and women alive today were married as children, and complications relating to pregnancy and childbirth remain the leading causes of death among teenage mothers. In areas with a concentrated HIV epidemic, a disproportionate number of male adolescents who have sex with men or adolescent boys are living with HIV. They are in need for comprehensive sexual health education, as well as prevention and treatment of HIV and AIDS.

Global health emergencies, conflicts and the effects of the climate crisis can reduce access to SRH services and deny people's rights, widen gender inequalities and increase forced marriage. Emergencies often hinder women's and girls' access to SRH services by preventing them from accessing health facilities or by disrupting supply chains, limiting the availability of essential supplies such as contraceptives.[10]

During the second year of the COVID-19 pandemic, one-third of countries reported disruptions to sexual, reproductive, maternal, newborn, child, and adolescent health services.[11]

A 10% drop in reproductive healthcare due to COVID-19 equals serious health consequences in low- and middle-income countries

49 MILLION
more women with unmet need for modern contraception

15 MILLION
more unintended pregnancies

168,000
more newborn deaths

28,000
more maternal deaths

3 MILLION
more unsafe abortions

Source: Guttmacher Institute, 2021[12]

The pandemic and the response to it also led to an increase in GBV and harmful practices like child marriage and FGC. Women and girls in crises and humanitarian disaster settings are at an even higher risk of GBV and human trafficking. Such abuses contribute to unintended pregnancies, unsafe abortion, and maternal mortality, and violate human rights.[13] Thirty-five million women of reproductive age need humanitarian assistance. Their needs do not disappear in crisis.

4. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS...

...need gender equality

The delivery of SRHR must be driven by a rights-based, gender-transformative approach, predicated on the right to health for all. The UNCRC calls specifically for children and adolescents to be protected from all forms of physical and mental abuse and sexual exploitation, to have access to healthcare facilities and information,[14] and to receive the highest attainable standard of health. A gender-transformative approach analyses, questions, and transforms inequitable and harmful gender norms, and addresses power imbalances and gender-based violence.

SRHR must be applied using a human rights lens and guided by the core principles of human rights: SRHR need to be universal, meaning that they apply equally to all people, regardless of age, sexual orientation, gender identity, gender expression and sex characteristics, disability, religion, and ethnicity, without exceptions. SRHR are inalienable and indivisible: the denial of one right impedes the enjoyment of all others.

The four core child rights principles – non-discrimination, the best interests of the child, the right to survival and development, and the right to be heard – emphasize the need for governments to apply SRHR measures for different groups, including men and boys, yet particularly girls facing intersecting levels of discrimination, who are more at risk of SRHR violations.

...are a key component of reproductive, maternal, newborn, child and adolescent health

SRHR are a central component of the reproductive, maternal, newborn, child and adolescent health (RMNCAH) continuum of care. SRHR centres on individual autonomy and ensuring that everyone is able to make their own choices regarding reproduction and sexuality and to enjoy the highest attainable standard of health.[16]

In 2017, every day, approximately 810 women died from preventable causes related to pregnancy or childbirth.[17] Ninety-four percent of these deaths occurred in low and lower middle-income countries where women and girls are unable to access adequate health services. Getting pregnant too young is a key risk factor for complications in pregnancy and childbirth: the risk of maternal mortality is highest for girls under 15 years old. Complications in pregnancy and childbirth are also higher among girls aged 10–19 than women aged 20–24.[18] Improved care around the time of birth and afterwards can save the lives of women, girls and their newborns.

Babies born to mothers under 20 years of age face higher risks of low birth weight, preterm delivery and severe neonatal conditions.[19] Increasing access to modern contraception and quality maternal care, creating supportive healthcare systems and policies, and building supportive community environments for safer pregnancies could prevent one in three maternal deaths and one in five child deaths.

SRHR has direct implications on other components of RMNCAH too. For example, increased knowledge about prevention and treatment of HIV, and access to testing and treatment for HIV, can prevent mother-to-child transmission during pregnancy, labour and delivery, and breastfeeding. Similarly, human papillomavirus (HPV) vaccinations amongst young girls can prevent future risks of cervical cancer.

...are especially urgent for adolescents

Adolescents often lose out on SRHR. They are overlooked in SRH programming and services. GBV interventions tend to be age-blind, while child-focused interventions tend to overlook SRH and are also often gender-blind and insensitive to people of all genders. Adolescents and young people[20] are often turned away from health facilities because they are not married or 'of age'. They frequently face discrimination in accessing health services or receiving SRHR information. Adolescent girls and young women are doubly marginalized, being excluded both by their age and their gender.

Adolescent girls frequently experience complications during pregnancy and childbirth, which is the leading global cause of death among 15–19-year-old females.[21] Adolescent pregnancies contribute to high child mortality as children of mothers younger than 16 are two to four times more likely to die at all stages in sub-Saharan Africa and South Asia, even after controlling for maternal education and health-seeking risk factors.[22]

5. SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS UNDER THREAT

Despite the various global commitments, weak political leadership, disinvestment, and social barriers continue to threaten the gains made in SRHR and negatively affect the well-being of all people.[23] Services are highly dependent on the legal, political and societal situation of individual countries, and policy and legislation on comprehensive SRHR differs greatly.

Around **76%** of countries

have supportive SRHR laws and policies in place, yet not all countries cover all components of SRHR, and there are significant variations within and between regions. Implementation of laws and regulations may vary too.[24] Only one-third of countries in Latin America and the Caribbean, East and Southern Africa, West and Central Africa, Asia and the Pacific have laws and policies in support of services such as safe abortion; yet there exist restrictive rights-based policy and legislation.

Many of those who oppose comprehensive SRH services also oppose rights-based and evidence-driven approaches to adolescent SRHR such as CSE and the full range of SRH services for all. This is particularly evident in attempts to undermine growing social acceptance of people of diverse sexual orientations, gender identities and expressions as well as sex characteristics, but also in attempts to control adolescent sexuality, especially that of girls.

According to the Center for Reproductive Rights, a global legal advocacy organization dedicated to advancing reproductive rights, in many parts of the world, there has been a rising backlash against gender equality – particularly sexual and reproductive rights – with opposition groups attempting to roll back legal and policy protections at national, regional and global levels.[25]

This regression has harmful implications for men and boys, for women and girls, as well as for human rights defenders working to promote SRHR and the funding and prioritization of SRHR. In many countries an emboldened opposition has influenced legislation, policy and practices, and even Supreme Court decisions, and impeded SRHR progress.

Donor governments are sometimes a barrier to fostering access to SRHR. For example, conservative US presidents and their administrations put limitations on access to SRHR through harmful policies such as the Protecting Life in Global Health Assistance policy, which prohibits any foreign non-governmental organizations (NGOs) to certify that they would not "perform or actively promote abortion as a method of family planning" using funds from any source (including non-

U.S. funds) as a condition of receiving U.S. government global health funding.[26] Conservative US governments have also historically deprioritized U.S. foreign assistance funding for family planning.

Recent political developments in the UK suggest, that despite its legacy as a stalwart supporter of SRHR (the UK was a leading architect of Family Planning 2020, a global partnership to invest in rights-based family planning) the UK government's pro-choice abortion stance is faltering, which national health NGOs attribute to the lobbying tactics of emboldened anti-abortion Christian groups.[27] In Eastern European countries, such as Poland, there is a similar opposition from the current conservative government to rights to access comprehensive sexual and reproductive health, including sexual health education, in vitro fertilization (IVF) or abortion.

The future of funding of SRHR through official development assistance (ODA) and donor investments is uncertain. We are witnessing a reduction in SRHR funding from donor governments such as the UK. As countries grapple with the effects of COVID-19, this represents a sizable setback in global health goals.[28] The UK's cut to ODA in 2020 considerably reduced family planning contributions, for example leading to an 85% cut in UK funding to United Nations Population Fund (UNFPA) Supplies, a program that distributes low-cost family planning commodities around the world.

While some donors continue to champion SRHR in the UN Commission of Population and Development and the UN Commission on the Status of Women, the Funding for Sexual and Reproductive Health and Rights report[29] states that health ODA will compete with emerging donor priorities such as the climate crisis. The report also states that there is evidence to suggest that development agencies face increased pressure to shift their funding from social sectors to economic productive sectors.

6. BARRIERS TO ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Supportive policy and legislation are not the only factors determining whether SRHR is accessible for all. Physical and cultural barriers also prevent people from benefiting from SRH services that exist. When commodities are not supplied in adequate volumes and/or primary healthcare centers offering those services are too far away, the populations most in need remain without access. A lack of skilled health workers to deliver comprehensive SRH services restricts men's, women's and adolescents' access to those services.

One mechanism for governments to define priority services and ensure they are accessible to all is to include them in the essential package of health services (EPHS). Research conducted in 24 low- and middle-income countries in 2015[30] details which SRH services are integrated into national EPHS plans. It found that CSE and SAS fared badly – potentially reflecting the restrictive policies and laws in place in these areas.

Even when SRH services are included in an EPHS, there is no guarantee that people can access these services without incurring financial hardship. Costs are a key barrier for access in many countries where SRH services are not covered by insurance schemes, tax, or funded by donors. This leads to out-of-pocket spending and inequities in access, affecting those most subject to systemic inequity. Shortages of necessary SRH services within primary healthcare clinics pose an additional barrier.[31]

Harmful gender norms and the resulting inequalities challenge delivery and access to quality services for adolescents. Countries rarely prioritize adolescent SRHR. Restrictive socio-cultural norms, including some religious beliefs, are a further barrier. Raising social awareness and changing harmful social norms and beliefs on SRHR, such as through individual and group discussions at community level, are critical. Healthcare workers and service providers must be trained and equipped to provide respectful and responsive care, and supported by social and behavioral change interventions to shift norms that contribute to provider bias.

Furthermore, decision-making processes on SRHR often have low involvement of communities and CSOs in EPHS processes. Only five of 16 countries (of the 24 LMICs where information was available) include CSOs and communities in these processes.[32]

7. WHAT IS SAVE THE CHILDREN DOING?

Save the Children delivers high impact SRHR interventions in more than 30 countries around the world.

Our approach to SRHR prioritizes those most affected by inequality and discrimination, particularly adolescents and people living in humanitarian settings. Our programs are comprehensive and work at multiple levels – individual, community, health and education systems, and policy – to promote SRHR. We reach individual adolescents, women, and men with age- and life-stage tailored comprehensive SRHR information and support to cultivate self-esteem, self-efficacy, life skills, linkages with health services, and gender-equitable attitudes and behaviors. At the same time, we engage partners, families, parents, and communities to foster more positive attitudes, behaviors, and norms around SRHR and gender. We provide technical assistance to strengthen health systems to deliver high quality, comprehensive community- and facility-based SRH services and information for adolescents and adults of all genders. In humanitarian settings, we ensure SRHR is part of a comprehensive humanitarian response. Finally, we provide technical assistance and support adolescent- and community-led advocacy and accountability for policies that support SRHR at national, regional, and global levels.

Save the Children promotes child, adolescent, and community participation and leadership in the design and delivery of SRHR programs as well as in advocacy and accountability initiatives. We integrate SRHR into other health services and other sectoral approaches to contribute to adolescent well-being and broader health and development goals.

REACH: Reaching and Empowering Adolescents to make Informed Choices for their Health ([33])

From 2018–2021, Save the Children implemented a gender transformative comprehensive adolescent SRHR program in three states of Northern Nigeria: Gombe, Katsina and Zamfara. As part of this program, we trained and supported members of Children's Parliaments to advocate to the government on a gender-responsive adolescent SRHR. Elected members of Children's Parliaments participate in each of the state-level Houses of Assembly and advocate on issues affecting children, adolescents, and young people with decision-makers.

1. **REACH provided training to Children's Parliaments on how to facilitate peer consultations on adolescent SRHR and how to formulate and implement an effective advocacy strategy.**
   The Parliaments, together with CSOs, have continuously engaged with the 37 Child's Rights Advocacy Clubs and wider groups of children across all three states to represent their perspectives on the challenges they face when making informed choices about their SRHR and well-being. Girl representatives in the Children's Parliaments have served as role models to other girls.

2. **REACH trained Children's Parliaments on how to pass the Child Rights Act and how to audit government plans and monitor budgets to ensure adolescent SRHR is adequately resourced.**
   Joint budget advocacy by the Children's Parliaments and CSOs led to increased allocations for ASRHR in Gombe and Katsina's state budgets. Gombe allocated 12 million naira (≈27,601.22 USD)[34] to adolescent SRH services in 2021, up from 0 naira in 2020. Katsina allocated 3.9 million naira (≈8,970.02 USD)[35] in 2021, up from 3.4 million naira in 2020. Coalition advocacy led to the passage of the Child Rights Act in Katsina in November 2020, while government stakeholders in Gombe and Zamfara committed to make progress on the domestication of the Act. The Act was recently passed in Zamfara mentioning the support of the REACH project.

3. **Following training, Children's Parliaments advocated for adolescent SRHR alongside CSOs.**
   Members of Children's Parliaments, in collaboration with CSOs, carried out advocacy and public engagement activities focusing on adolescent SRHR across the three states. 100 children (45 male and 55 female) participated in sessions on the government budgeting process and the implication of budget policy for the development and well-being of citizens in their states.

> ***"Now that the project is over I can say it has been a success. Children in the parliaments told me their parents religious and traditional leaders recognize the importance of girl education, so now they can freely go to school. Because they are informed, they will also go for antenatal care and medical things."***
>
> **Aisha Idris Nakano,**
> **House Leader Children's Parliament**

> ***"Participation in the Children's Parliament has built confidence in me, I can now talk and negotiate with anybody when it comes to my needs and to advocate for that of my peers. Thank you Save the Children."***
>
> **Abubakar Muhammadu Auwal, Speaker,**
> **Zamfara Children's Parliament**

Save the Children supports the realization of children's rights, including the SRHR of girls and women, by supporting civil society and children to monitor gaps in rights fulfillment and feed this into the UN Committee of the Rights of the Child's national-level review processes. Governments are obliged to report to the Committee on how well they are delivering services to children and where they should improve implementation.

In 2020, Save the Children supported a coalition of organizations in Mozambique to prevent and end child marriage to submit a comprehensive alternative report to the Universal Periodic Review of the UN Human Rights Council, highlighting a number of key concerns on SRHR in the context of COVID-19.[36]

We aim to support governments by ensuring they hear citizens' concerns, and their views on how these concerns can be addressed. Around the world, we support CSOs and children to share the results of their monitoring in alternative reports. The UNCRC Committee always addresses health concerns and specific concerns and issues like FGC, and child marriage are often issues, which civil society highlights to their governments as particular obstacles to the implementation of their rights. Such reports, developed using a localized approach, reflect the conditions on the ground.

8. RECOMMENDATIONS

Need for comprehensive SRHR services and policies

- Governments should integrate a comprehensive package of SRHR services and policies, including SAS, as part of universal health coverage. Services should be tailored to respectfully serve adolescents and those most affected by inequality and discrimination.
- Governments should develop comprehensive and resourced plans for how to tackle SRHR violations, including all forms of GBV, and address root causes such as inequitable social and gender norms and economic concerns for families.
- SRH services must be included in national health plans, policies and strategies.
- SRH services must be considered an essential service during a pandemic, such as COVID-19, as well as during other emergencies and crises.
- SRHR policies should be integrated into national adolescent health and well-being strategies, calling for multi-thematic interventions, thus framing adolescent SRHR within broader adolescent development.

Enabling environment for SRHR and strengthening health and governance systems

- Governments should foster an enabling political environment for strong and efficient institutions with staff that have the right skills and act according to legal policies.
- Governments should ratify, domesticate and implement, without reservations, all international and regional agreements on SRHR.
- Governments must protect and advance language on the comprehensive package of SRHR in global fora such as the United Nations General Assembly and World Health Assembly.
- Governments should strengthen health and governance systems for SRHR, including by investing in resourcing and capacity enhancement of health workers (including community health workers) to provide adolescent- and gender-responsive SRH services and strengthen health systems to respond to the needs and rights of adolescents.
- Governments should provide for service delivery policies that promote the comprehensive package of SRHR services for adolescents; without restrictions based on age or marital status and without any requirements for partner consent, in line with SDG commitments to tackle barriers to access to SRH services.
- Governments should make inclusive policy reforms addressing the rights of children, adolescents, and young people and the issues concerning them, including their right to be heard and taken into account on matters that affect them.

Funding for SRHR and removing barriers to SRH access

- SRH services and rights for all people (regardless of age, sexual orientation, gender identity and expression, and sexual characteristics) should be a resourced priority of national governments.
- Governments should increase their national health budgets and provide robust financing for SRH services, including through specific budget lines for SRHR and adolescent SRHR, both of which should be integrated into national costed health services plans.
- This includes increased funding to ensure universal access to the full range of contraceptive services; with a particular focus on hard-to-reach areas that are frequently affected by humanitarian crises.
- Governments should increase funding for SRHR by mobilizing additional domestic resources, for instance through taxation reforms.
- Donor governments should provide sustainable and adequate funding of SRHR to countries.
- Donors and national governments should remove financial and non-financial barriers to access healthcare services, including reducing out-of-pocket spending – especially for those most affected by inequality and discrimination – to provide free adolescent SRHR services for all.
- Governments and local actors must work to remove legal constraints, reduce stigma and increase demand generation for adolescent SRH and wider health services.

Guaranteeing comprehensive sexuality education (CSE)

- Governments should include CSE in policy and legal frameworks and increase coverage and comprehensiveness of sexual health education.
- Governments should increase national and subnational budgets for CSE both in and out of school settings.
- Governments should invest in CSE training and support for teachers and other workers that provide CSE in and out of school settings.
- Governments should ensure implementation of CSE, both in and out of school settings, which is responsive to the age and developmental stage of children, adolescents and young people, as well as rights-based, gender transformative, scientifically accurate, and inclusive.
- In times of protracted crisis, such as conflict and climate-related shocks and global health emergencies, governments need to ensure the continuation of CSE, especially for adolescents, for example through remote CSE.

Sexual and reproductive health and rights in humanitarian settings

- Governments should invest in multisector interventions to prevent sexual and GBV in humanitarian settings, including in resources for SRHR and psychosocial support.
- Governments should integrate contraceptive services into national and decentralized disaster preparedness plans and include adolescent SRHR in Minimum Initial Service Packages in planning, funding, and implementation for humanitarian response.

Meaningful participation of adolescents

- Governments should acknowledge adolescents' rights to meaningful engagement and establish mechanisms that facilitate adolescents' meaningful participation in the design, implementation, and monitoring of SRHR policies.[37] Adolescents should be able to effectively contribute to advocacy, governance, and accountability efforts in SRHR decision-making processes.
- Governments should institutionalize adolescents safe and meaningful participation in decision-making processes on SRHR through the establishment, resourcing, and implementation of local- and national-level laws, policies, and guidelines recognizing adolescents' agency and rights as key stakeholders in their own lives.[38]

Monitoring, accountability and transparency

- Governments should include and prioritise gender- and age- disaggregated data in health information systems to monitor accessibility to SRHR services, monitoring, reporting and referral mechanisms. All data should be disaggregated by age- and sex at a minimum and, where safe and possible, by disability, ethnicity, geography, wealth, sexual orientation, and gender identity and expression.
- Governments should be held accountable for the provision of comprehensive and equitable SRH services based on state obligations, such as existing legislation, budgetary expenditures, or other institutionalized processes.

GLOSSARY

ASRHR: Adolescent Sexual and Reproductive Health Rights.

CSE: Comprehensive Sexuality Education enables young people to protect and advocate for their health, well-being and dignity by providing them with a necessary toolkit of knowledge, attitudes and skills. It is a precondition for exercising full bodily autonomy.

CSO: Civil Society Organizations are non-state, not-for-profit, voluntary entities formed by people in the social sphere that are separate from the state and market.

EPHS: Essential Package of Health Services includes preventative, promotive, curative, rehabilitative and palliative health services aimed at individuals typically delivered through community level, primary healthcare facilities, first level hospitals, tertiary level hospitals and at the population level.

FGC: Female genital cutting is the practice of partial or total removal of the external genitalia or other injury of girls and young women for non-medical reasons.

GBV: Gender-Based Violence refers to harmful acts directed at an individual based on their gender and is rooted in gender-inequality, the abuse of power and harmful norms. It is a violation of human rights and a life-threatening health and protection issue.

HPV: Human Papilloma Virus is the most common viral infection of the reproductive tract and mainly transmitted through sexual contact.

IVF: In vitro fertilization is a form of reproductive assistive technology in which an egg is fertilized outside the body.

LMIC: Low- and Middle-Income Countries are those with a GNI per capita of $1,086-$4,255.

NGO: Non-Governmental Organizations are non-profit entities that operate independent of governmental influence.

ODA: Official development assistance is government aid that promotes and specifically targets the economic development and welfare of developing countries.

RMNCAH: Reproductive, Maternal, Newborn, Child and Adolescent Health.

SAS: Safe abortion services.

SDG: Sustainable development goals are a collection of 17 interlinked global goals designed for people and the planet, set up by the United Nations General Assembly, intended to be achieved by 2030.

SRH: Sexual and reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system.

SRHR: Sexual and reproductive health rights are defined by the Guttmacher Institute as a person's right to bodily autonomy, freely define their own sexuality, decide whether and when to be sexually active, choose their sexual partners, have safe and pleasurable sexual experiences, decide when, whether and whom to marry, and decide whether, when, and how often to reproduce. SRHR also includes access to information, resources, services, and support necessary to achieve the given list, free from discrimination, coercion, exploitation and violence.

STI: Sexually transmitted infections are spread predominantly through sexual contact, sometimes spread through pregnancy, childbirth, and breastfeeding. STIs have a profound impact on health.

UHC: Universal healthcare means that all individuals and communities receive the health services they need without suffering financial hardship.

UNCRC: United Nations Convention on Rights of the Child, established in 1990, is a legally binding international agreement setting out the civil, political, economic, social and cultural rights of every child, regardless of their race, religion or abilities.

UNFPA: United Nations Population Fund is the United Nations sexual and reproductive health agency.

ENDNOTES

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Save the Children

Save the Children believes that poverty does not just apply to income or wealth but also encompasses multi-dimensional aspects, such as lack of access to education, health, housing, nutrition, sanitation or water, and to inequality.

This report was written by Marionka Pohl. The author greatly appreciates contributions from Smita Baruah, Elo Otobo, Callie Simon, Kiki van Kessel, Margot Nauleau, Doris Mpoumou, Marie Busk Larsen, Piotr Kabala, Taryn Russell, Samiera Zafar, Rabeca Lauriciano, Shannon Pryor, Paula Sengo, Rahinatu Hussaini, Hanne Lotte Moen, Margaret Pruitt.

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Published by
Save the Children International
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savethechildren.net

Company registration number 3732267 (England and Wales)
Charity registration number 1076822

First published 2022