Leaving no one behind

Universal health coverage and sexual and reproductive health and rights
Who we are

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

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

Acknowledgements and credits

This study has been made possible by funding from the IPPF Japan Trust Fund for HIV and Reproductive Health.

The literature review was conducted by Kazuyo Machiyama from the London School of Hygiene and Tropical Medicine. The country case studies have been developed by consultants and staff from IPPF Member Associations: Afghanistan – Akmal Samsor (consultant), Homaira Abawi and Samiullah Sami from the Afghan Family Guidance Association; Cambodia – Keovathanak Khim (consultant) and Var Chivorn from the Reproductive Health Association of Cambodia; Sudan – Sara Eltegani Saied (consultant), Bashir Imam, Alshafei Mohamed Ali, Nagat Mohamed and Mahmoud Elhadi from the Sudan Family Planning Association; Kenya – Charles Omondi (consultant), Edward Marienga and Gordon Ochieng from Family Health Options Kenya.

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## Key abbreviations

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<tr>
<td>AFGA</td>
<td>Afghan Family Guidance Association</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>FHOK</td>
<td>Family Health Options Kenya</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GDP</td>
<td>Gross domestic product</td>
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<td>HIV</td>
<td>Human immunodeficiency virus</td>
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<td>IDP</td>
<td>Internally displaced person</td>
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<td>LMIC</td>
<td>Low- and middle-income countries</td>
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<td>MA</td>
<td>Member Association</td>
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<td>MOFA</td>
<td>Ministry of Foreign Affairs</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<td>PHC</td>
<td>Primary healthcare</td>
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<td>RHAC</td>
<td>Reproductive Health Association of Cambodia</td>
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<td>SDG</td>
<td>Sustainable Development Goal</td>
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<td>SFPA</td>
<td>Sudan Family Planning Association</td>
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<td>SRH</td>
<td>Sexual and reproductive health</td>
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<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
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<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>UHC</td>
<td>Universal health coverage</td>
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<td>UNDP</td>
<td>United Nations Development Programme</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UN OCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Leaving no one behind: Universal health coverage and sexual and reproductive health and rights

Foreword

Ministry of Foreign Affairs, Japan

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

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

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

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

International Planned Parenthood Federation

Universal access to sexual and reproductive health and rights is critical to achieving universal health coverage and thereby the Sustainable Development Goals. Universal health coverage must promote women’s, men’s, children’s and adolescents’ mental and physical health and ensure sexual and reproductive health and rights without discrimination of any kind. It must include addressing barriers people face when seeking these services and ensure they are available, accessible, acceptable and of good quality.

Leaving no one behind: Universal health coverage and sexual and reproductive health and rights is a synthesis of evidence revealed from a literature review commissioned by IPPF. The results highlight underfunding of sexual and reproductive health including: substantial out-of-pocket expenditure among poor households resulting in financial hardship; critical sexual and reproductive health services such as gender-based violence services not being included in the essential healthcare packages and poorly run health facilities that do not serve the needs of the vulnerable and marginalized.

As a locally owned, globally connected movement for change in sexual and reproductive health and rights, IPPF supports countries to achieve universal health coverage. As shown through the case studies in the report, the IPPF Japan Trust fund for HIV and Reproductive Health has supported IPPF Member Associations to deliver essential, lifesaving, cost-effective, stigma-free sexual and reproductive health services. These efforts have contributed to strengthening national health systems and reaching the poorest, vulnerable and marginalized, bringing us closer to achieving universal health coverage.

Yilma Melkamu
Programme Director, IPPF
About this report

To inform the sector and wider stakeholders working on sustainable development, IPPF commissioned a study to review literature on the importance of sexual and reproductive health and rights in achieving universal health coverage. The study discusses the linkages between the two in terms of reaching the Sustainable Development Goals and also how progress on and challenges to universal access to sexual and reproductive health and rights have impacted on achieving universal health coverage. The study consists of a literature review undertaken by a consultant and documentation of case studies from IPPF Member Associations.

The literature review focused on studies that addressed population coverage with quality sexual and reproductive health and rights and financial protection, including health expenditure on sexual and reproductive health. Studies published in English between 2010 and 2017 were searched using keywords in electronic databases PubMed and Popline. Furthermore, reference lists of related articles and resources from an agreed group of multilateral institutions, governments, and non-governmental organizations, including those of IPPF, were cross-referenced and searched. Studies and documents that did not focus on essential elements of sexual and reproductive health and rights were excluded. This report includes a summary of findings from the literature review.

The case studies were developed to illustrate the realities on the ground in achieving universal access to sexual and reproductive health and rights. Each case study focuses on a specific area of sexual and reproductive health and rights that must be addressed for universal health coverage, leaving no one behind. Consultants undertook the documentation in each country, which included a review of policy papers, discussions with relevant government and non-governmental stakeholders and a desk review of relevant literature.
Executive summary

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

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

Universal access to sexual and reproductive health is highlighted in the Sustainable Development Goals as a driver to ensure healthy lives and well-being (Goal 3) and achieve gender equality and women’s empowerment (Goal 5). Comprehensive sexual and reproductive health services must be provided as a centrepiece of universal health coverage to protect gains and accelerate progress towards other Sustainable Development Goals. Women, men and young people around the world must be able to realize the right to health, which includes sexual and reproductive freedom and other basic human rights related to family life, and also participation in social, economic and public spheres.

The study commissioned by IPPF provides evidence of the challenges to and benefits of universal access to sexual and reproductive health and rights. Corresponding with the main components of universal health coverage, the review focused on studies and documents that addressed:

- population coverage with sexual and reproductive health services
- population coverage with financial protection to meet sexual and reproductive health needs, and
- how sexual and reproductive health services and financial protection schemes are extended to whole populations, with no exceptions.

THREE DIMENSIONS TO UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH

Adapted from: WHO World Health Report 2010
Poor sexual and reproductive health services threaten universal health coverage

The unmet need for sexual and reproductive health services continues to be unacceptably high, despite various initiatives, laws and policies that prioritise access to family planning services:

- Globally, an estimated 214 million women who want to delay or avoid pregnancy are not using modern methods of contraception, highlighting the limited rights to sexual and reproductive health among women of reproductive age.

- Progress in access to antenatal care has been slow over the past 25 years. Only 52% of pregnant women received the recommended minimum of four visits in 2015.

- Coverage of cervical cancer screening in developing countries, where 83% of cervical cancer cases worldwide occur, is 19% on average, compared to 63% in developed countries.

A large number of studies consistently present coverage disparities in essential sexual and reproductive health services by wealth, age, educational level and where people live.

Diverse populations have different sexual and reproductive health needs. To ensure universal access to sexual and reproductive health, a people-centred approach to health services is essential. However, the health service package offered in many developing countries as part of universal health coverage only addresses a limited number of sexual and reproductive health issues and is not sensitive to the diverse needs of population groups such as young people and vulnerable and marginalized women and girls, who face particular challenges:

- Globally, between 1990 and 2015 the birth rate among adolescent girls aged 15–19 only went down from 59 births per 1,000 girls to 51.

- Adolescent girls and young women aged 15–24 years are at high risk of HIV infection, accounting for 20% of new HIV infections among adults worldwide in 2015 despite being only 11% of the adult world population. The gender imbalance is more profound in sub-Saharan Africa, where 25% of new infections among adults were reported among girls and women in this age group.

- Young women in many low- and middle-income countries face risk of child marriage. In developing countries 35% of young women aged 20–24 marry below the age of 18, and 12% below the age of 15. In South Asia, almost half of all young women marry before the age of 18. Young married and unmarried women are also at greater risk of sexual and gender-based violence.

Worldwide, there are 1.2 billion people aged 15–24, including many who are marginalized and vulnerable. They have a range of sexual and reproductive health needs, but their access to quality sexual and reproductive health services such as contraception, HIV prevention and treatment, safe abortion care, and sexual and gender-based violence services is limited. Reasons for this include poor access to information, harmful cultural practices, restrictive laws, and stigma among healthcare workers and in their communities.
Out-of-pocket expenditure and insufficient financial commitment hamper universal health coverage

The literature review found a lack of good quality studies assessing spending on sexual and reproductive health, particularly on household expenditure. However, it is clear that expenditure on health in low- and middle-income countries relies heavily on households making out-of-pocket payments. With sexual and reproductive ill health disproportionately affecting people in low- and middle-income countries, a significant proportion of the out-of-pocket health expenditure is spent on addressing these needs. For example:

- Over 38% of total expenditure on sexual and reproductive health services in Bihar – one of India’s poorer states – was paid out-of-pocket, while in Karnataka – an economically more prosperous state – it was 22%.\(^{12}\)
- Among a total household out-of-pocket expenditure on general health, families in Kenya spent 14% on sexual and reproductive health services.\(^{13}\)

The poor spend a higher proportion of their incomes on health, impoverishing them further. Moreover, a literature review found that women systematically made higher out-of-pocket payments than men, partly due to the high financial costs related to delivery care and other reproductive health services.\(^{14}\)

A substantial proportion of spending on sexual and reproductive health services is currently paid by individuals due to lack of financial protection and insufficient government and donor funding. For instance, contraceptive commodities are not covered by national insurance in many countries. In 2014 more than US$1.2 billion was spent on contraceptive supplies across 135 low- and middle-income countries. The share of individuals who paid for their own contraceptive supplies was 58%, while all donor funding and domestic government expenditure on supplies were at 25% and 17%, respectively.\(^{15}\) Funding for sexual and reproductive health, especially sexual health, has fluctuated and cannot be expected to grow significantly beyond the current levels. This means that increasing focus on mobilizing domestic resources in support of sexual and reproductive health services will be essential.\(^{16,17}\)

Several governments have introduced financing mechanisms to alleviate poverty as a result of seeking reproductive healthcare, such as cash transfers, voucher systems and user fee waivers, which in general have an impact on increased take-up of health services. However, the key to protecting people from financial hardship is to ensure that most funds for the health system are prepaid through some type of insurance scheme or tax, and that services are purchased from these pooled funds in a way that limits the need for out-of-pocket payments.\(^{18}\) Although national, social, community-based or public health insurance schemes or tax-funded health services exist in developing countries, the populations that are covered by such schemes are limited. People working in the informal sector and the most vulnerable and under-served groups such as young people and refugees are left behind. Moreover, the services covered by these schemes often do not include comprehensive sexual and reproductive health services.

Stigma and discrimination prevent serving the marginalized and vulnerable

Stigma and discrimination must be tackled in order to create an enabling environment for specific groups to realize their rights to sexual and reproductive health: for example, stigma towards HIV and people living with HIV is a significant barrier to accessing much-needed services.\(^{19}\) Unmarried young people also face considerable obstacles in accessing sexual and reproductive
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health services. Stigma is a major barrier, often exacerbated by the belief that young people cannot or should not make autonomous decisions about sex and sexuality. For example, young people face unique challenges when seeking abortion services and can be disproportionately affected by abortion stigma. In some settings, their access to sexual and reproductive health services is denied in spite of the existence of supporting policies.

Attitudes, practices and knowledge among healthcare workers affect the quality of sexual and reproductive health services provided to people from diverse backgrounds. For example:

- Lack of confidentiality among healthcare workers was a key issue that affected women living with HIV seeking antenatal care.
- A study of Afghanistan healthcare facilities in terms of providing gender-based violence services indicated major gaps in healthcare providers’ knowledge and attitudes and their role in helping survivors.

Addressing the challenges to universal access to sexual and reproductive health brings substantial health, social and economic benefits to communities and countries, and thereby ensures sustainable development.

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

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

For example, providing access to family planning would prevent 67 million unintended pregnancies and approximately 25 million unsafe abortions every year. It is also estimated that it would reduce maternal deaths by 76,000, newborn deaths from 2.9 million to 660,000 and HIV infections in newborns from 130,000 to 9,000 every year. One of the key social benefits of family planning is the subsequent improvement in levels of education and gender equality. When individuals have control over sex and reproduction and are safe and healthy in their sexual and reproductive lives, they are better able to participate in education and the labour market, to care for themselves and their families, and have more capacity to contribute to their communities and societies.

Making sexual and reproductive health services affordable will prevent people from falling into poverty

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

Leaving no one behind to achieve universal health coverage

Universal health coverage must be situated within a broader framework to address the underlying social determinants of health and make health systems not only functional but also free of barriers such as social exclusion and discrimination, lack of information and lack of decision-making power to seek healthcare. An approach that fails to address barriers to sexual and reproductive health and rights, including stigma, discrimination and gender inequality, or to make sexual and reproductive health and rights information and services available, accessible, acceptable and of good quality, does not constitute the full implementation of universal health coverage.

Equitable access to sexual and reproductive health and rights is still far from universal and the most marginalized and vulnerable are left behind. Even when people have access to these services, lack of social and financial protection mean that sexual and reproductive health is largely paid for by individuals and households. Ensuring sexual and reproductive health information and services as part of a core package of essential health services that is universally available and affordable leads to progress towards universal health coverage, realizing the right to health for all.
IPPF’s contribution to universal health coverage

IPPF is a global service provider and a leading advocate of sexual and reproductive health and rights* with a worldwide movement of national organizations (called Member Associations or MAs) working with and for communities and individuals in 153 countries. By promoting universal access to sexual and reproductive health services that are stigma-free, good quality and affordable for everyone, IPPF contributes to universal health coverage.

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

Some populations are more vulnerable to sexual and reproductive ill health and lack access to quality health services, supplies and information due to certain characteristics including age, gender, gender identity, ethnicity, sexual orientation, HIV status, education, disability, migrant status, and the stability of their environment, or they are denied access because of cultural practices or due to restrictive laws and policies. IPPF addresses these obstacles by challenging stigma and discrimination, using disaggregated data to focus attention on population groups that are most under-served, and advocates for policies which ensure that the marginalized have access to the services and information they need. These interventions have enabled IPPF to reach 47.2 million poor and vulnerable people, including 3.2 million needing humanitarian assistance, and provide 74.8 million sexual and reproductive health services to young people in 2016.

LEAVING NO ONE BEHIND: IPPF’S GLOBAL REACH

| 182.5 million sexual and reproductive health services delivered globally and 152.9 million (84%) in low- and middle-income countries | 59.6 million service users including 47.2 million (79%) poor and vulnerable people | 46,402 service delivery points, of which 23,364 (50%) are community-based distributors | 152 policy or legislative changes in support or defence of sexual and reproductive health in 72 countries |

* The right to have control over and decide freely and responsibly on matters related to sexuality, sexual health, and reproductive health free of coercion, discrimination and violence. A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

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

Understanding the financial burden that out-of-pocket healthcare expenditure puts upon the poor and vulnerable, IPPF MAs practise a ‘no-refusal policy’ to ensure every client receives the services they need regardless of their ability to pay. Championing universal access to sexual and reproductive health services, IPPF has advocated for policy changes that ensure affordable health services and commodities globally and nationally. In 2016, IPPF contributed to 175 changes in policy or legislation in support or defence of sexual and reproductive health and rights: nine policy changes at global level, 14 changes at regional level and 152 at country level. For example, after many years of advocacy, the Family Planning Association of India was successful in getting the Ministry of Health to include injectables in the list of contraceptive methods available free of charge under India’s national health programme.

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

A 46,402-strong service delivery network consisting of static clinics, mobile clinics, community-based distributors and associated clinics\(^\text{4}\) enables access to sexual and reproductive health services and essential medicines and commodities.

Trained and skilled healthcare workers, including medical professionals, peer educators, community health workers and volunteers, are key to delivering stigma-free sexual and reproductive health services. Recognizing the quality of IPPF’s service delivery, MA’s are contracted to build the capacity of government healthcare workers. For example, in 2016 the Family Guidance Association of Ethiopia, IPPF’s MA in Ethiopia, trained 10,000 healthcare providers in HIV, long-acting family planning methods, cervical cancer screening and management, and delivery of comprehensive sexuality education. Furthermore, IPPF’s strong distribution and supply chain resulted in 14,286 public and private partners receiving contraceptive commodities from IPPF last year, so that women and girls had uninterrupted access to a comprehensive method of their choice.

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

\(^\text{4}\) IPPF categorizes an associated clinic to be a clinic that belongs to private individuals, organizations or the public sector, which provides sexual and reproductive health services by trained doctors, clinicians and or counsellors. IPPF MAs have an agreement to provide significant technical support, monitoring, quality of care and oversight, and in some cases provide contraceptives and other sexual and reproductive health commodities to the associated clinic. An associated clinic is not managed by the IPPF MA and services are provided by the associated clinic staff.
Addressing gender-based violence to reach universal health coverage in Afghanistan

Afghanistan is a low-income country ranked 169th on the human development index\textsuperscript{26} and has a fragile health system. The main challenges of rebuilding Afghanistan’s healthcare system include lack of security, lack of infrastructure, economic hardship, poor coordination among government and healthcare providers, difficult access to healthcare facilities, unsuitable hospital conditions, and few trained healthcare workers, especially women.\textsuperscript{27}

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

Universal health coverage in Afghanistan

The Basic Package of Health Services and the Essential Package of Hospital Services in Afghanistan represent the approaches taken by the government to promote free universal coverage across the entire country since 2003,\textsuperscript{28} emphasising priority access to the groups in greatest need, especially women, children, people with disabilities and those living in extreme poverty.\textsuperscript{29} However, neither document includes a comprehensive approach to address the needs of survivors of gender-based violence. Studies suggest that 87% of Afghan women experience at least one form of physical, sexual or psychological violence and 62% experience multiple forms.\textsuperscript{30} Furthermore, healthcare facilities, which are often the only hope for survivors of gender-based violence to seek support, do not have the necessary infrastructure or trained staff to provide a comprehensive service.\textsuperscript{31}

Since 2005, the deterioration of the security situation has had a detrimental effect on the life of Afghans and the development effort, including access to and coverage of healthcare.\textsuperscript{32} In addition, an unhealthily large proportion of healthcare expenditure is sourced privately as out-of-pocket payments.

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

Gender-based violence in Afghanistan

Gender-based violence is a pervasive problem in Afghanistan. It stems from complex inequalities and cultural practices which, when aligned with poverty and lack of awareness, subordinate women to men and prevent them from acting on or receiving support.\textsuperscript{33}

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

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

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

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

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

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

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

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**EXPERIENCE OF PHYSICAL VIOLENCE AMONG EVER-MARRIED WOMEN IN AFGHANISTAN**

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<th>Background characteristic</th>
<th>% who have experienced physical violence since 15 years of age</th>
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<td>15–19</td>
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</tr>
<tr>
<td><strong>Marital status of women</strong></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>52.8</td>
</tr>
<tr>
<td>Divorced/separated/widowed</td>
<td>58.9</td>
</tr>
<tr>
<td><strong>Residence of women</strong></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>43.1</td>
</tr>
<tr>
<td>Rural</td>
<td>55.7</td>
</tr>
</tbody>
</table>

Source: Afghanistan Demographic and Health Survey 2015

* These good practices are part of the learning from an IPPF Japan Trust Fund project implemented by AFGA in 2012–2014
Leaving no one behind: Universal health coverage and sexual and reproductive health and rights

CAMBODIA

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

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

Universal health coverage in Cambodia

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

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

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

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

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

**POPULATION HEALTH AND HEALTH SERVICE INDICATORS**

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

Sources: Cambodia Demographic and Health Survey 2014

* The national poverty line defined as an absolute poverty line of 2,200 calories per person per day
offering STI services based on a syndromic approach.\textsuperscript{41} As a major provider of STI services, RHAC treated 59% of all clients seeking treatment for STIs in 2015. Between 2012 and 2016, RHAC received over 1 million clients, of which 15% were garment workers.

The garment industry is one of the main economic contributors in Cambodia, employing over 600,000 workers. Most are young, migrant, female and unmarried workers of reproductive age.\textsuperscript{42} In studies from 2012–2015, over 56% of garment workers reported having received treatment for an STI, but only 54% reported using condoms with a partner and only a small proportion were able to identify signs and symptoms of STIs.\textsuperscript{43,44}

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

Good practices in delivering sexual and reproductive health services to vulnerable garment workers\textsuperscript{*}

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

“Sometimes people don’t know about medicine, and some places aren’t safe. At RHAC, we know we will be safe... they know my needs as a woman. Most importantly I am assured of the high level of confidentiality they practise with client information.” \textsuperscript{45} A 27-year-old garment factory worker in Phnom Penh

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

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

“I support RHAC’s strategies on family planning and sexual and reproductive health because factory workers are mostly at reproductive age, and they should adopt family planning. Therefore, if RHAC is working to address this problem, factory workers will have children according to their plan and [their] ideal family size.” \textsuperscript{46} H.E Huy Han Song, Secretary of State of the Ministry of Labour and Vocational Training

* These good practices are based on learning from an IPPF Japan Trust Fund project implemented by RHAC in 2013–2015
Investing in adolescent and youth-friendly sexual and reproductive health and rights to achieve universal health coverage in Kenya

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

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

Universal health coverage in Kenya

The Kenyan government has committed to achieve UHC by 2030. In 2007 it launched a long-term development plan, Vision 2030, aiming to transform the country into an industrialised middle-income country and emphasising a high quality affordable healthcare system. The Health Financing Strategy of 2010 reiterated these commitments towards UHC. It emphasises social health protection for Kenyans through introducing social health insurance and tax financing for vulnerable populations. The National Hospital Insurance Fund is currently the main provider of health insurance, primarily funded through general revenue and member contributions. It provides formal-sector employees with compulsory insurance and informal-sector workers with voluntary insurance and covers 19.6% of the Kenyan population. However, inequality in overall health insurance coverage across Kenya is still high. One of the biggest challenges for the Kenyan health system is the inadequate coverage of financial protection for the informal sector, especially poor populations. The wealthy and those living in urban centres are more likely to have insurance than the poor and those in rural areas. Out-of-pocket payments for healthcare in Kenya are also high (26.6% in 2012/13). The proportion of the population incurring catastrophic health expenditure was 6.2% in 2013. Kenya’s health financing envelope is progressing gradually, but falls short of the 2001 Abuja Declaration in which African nations made a commitment to allocate 15% of their national budgets to the health sector.

Sexual and reproductive health coverage for young people in Kenya

Sexual and reproductive health and rights has been recognized as a priority within the Kenya Essential Package of Health, as outlined in Kenya’s National Health Sector Strategic and Investment Plan II 2013–2017. The government has committed to providing youth-specific services including reproductive health counselling, contraceptives and HIV-related services through the establishment of youth-friendly sexual and reproductive health services within existing health facilities. However, due to insufficient funding for youth-friendly services, access and coverage is variable in scope across the country and unequal between urban and rural areas. The sexual and reproductive health needs of more vulnerable groups within the youth population, such as lesbian, gay, bisexual and transgender youth, are also not adequately met in most health facilities. There is also a need to address the cultural, religious and traditional value systems that prevent healthcare workers from providing good quality and comprehensive sexual and reproductive health services to young people. Family Health Options Kenya (FHOK), IPPF’s member association in Kenya,
is working at the community level to provide youth-friendly services and comprehensive sexuality education for young people in and out of school.

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

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

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

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

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

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

**Programme Manager, FHOK**
Sexual and reproductive health services for internally displaced populations in Sudan

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

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

Universal health coverage in Sudan

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

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

Reaching internally displaced people in Sudan

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

SUDAN

SEVERITY OF HEALTH NEEDS MAP

Source: UN OCHA 2017

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

* The Zakat Chamber is a government body that makes annual deductions from Muslim citizens’ basic income and redistributes this income to the poor through support for the NHIF and other distribution mechanisms.
State-level reproductive health departments have started to refurbish clinics and build the capacity of health staff at primary and secondary levels to provide emergency obstetric and neonatal care, infection prevention and control, safe motherhood and family planning services to ensure the provision of quality services needed by IDPs.

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

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

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

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

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

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

**SEXUAL AND REPRODUCTIVE HEALTH SERVICES PROVIDED TO IDPs IN NORTH AND SOUTH DARFUR**

<table>
<thead>
<tr>
<th>Services provided to IDPs through mobile and satellite clinics</th>
<th>2015</th>
<th>2016</th>
<th>Up to Sept 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total sexual and reproductive health services provided to IDPs</td>
<td>32,416</td>
<td>53,486</td>
<td>59,794</td>
</tr>
<tr>
<td>Sexual and reproductive health services provided to women</td>
<td>19,765</td>
<td>47,561</td>
<td>39,857</td>
</tr>
<tr>
<td>Sexual and reproductive health services provided to young people</td>
<td>16,308</td>
<td>26,763</td>
<td>25,341</td>
</tr>
</tbody>
</table>

Source: Service statistics, SFPA

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

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

Executive Director, SFPA


References

Executive summary


Afghanistan


Cambodia


42. Ibid.

43. Ibid.

Kenya


Sudan


60. [nhif.gov.sd](http://nhif.gov.sd)

61. [nhif.gov.sd](http://nhif.gov.sd)


63. ibid.
Leaving no one behind: Universal health coverage and sexual and reproductive health and rights
ABOUT THE IPPF JAPAN TRUST FUND FOR HIV AND REPRODUCTIVE HEALTH

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

- contribute towards expanded and sustained access to integrated HIV and sexual and reproductive health services, in particular for people most vulnerable to HIV
- raise public awareness about the partnership between the Government of Japan and IPPF to respond to current global health challenges, through integrating HIV and sexual and reproductive health and realising human security.

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

Between January 2000 and November 2017, 55 IPPF Member Associations in Africa, Asia and the Middle East have received support from the Fund to implement a total of 138 projects. The breadth and scope of the Fund is evident in its spread and the array of projects – from increasing access to maternal and child health services in rural Pakistan to securing the sexual and reproductive health and rights of people living with HIV in Cameroon, and from reaching out to internally displaced people in Darfur to preventing HIV among factory workers in Samoa.

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