WHO & UNFPA Sexual and Reproductive Health and Rights and Universal Health Coverage Learning by Sharing Portal

VOLUME 2 DECEMBER 2025

INSIDE THIS ISSUE

- Adolescent sexual and reproductive health and rights
- Menstrual health and hygiene
- HIV/AIDS
- Maternal, newborn and child health
- Disability inclusion
- Access to safe abortion care

www.srhr.org/learn-uhc

FOREWORD

Significant progress has been made in advancing sexual and reproductive health and rights (SRHR) as part of universal health coverage (UHC), including expanded access to comprehensive services, legal and policy reforms, advancements in technology, reductions in maternal mortality, and a dedicated focus on adolescents and youth. With only five years remaining to achieve the 2030 Sustainable Development Goals (SDGs), the imperative to protect these gains—and close persistent gaps—has never been stronger.

In the wake of widespread funding cuts in 2025, investing in SRHR through UHC has become even more urgent. The abrupt reductions in official development assistance (ODA) threaten to reverse decades of progress in access to essential services, and to exacerbate inequalities—with devastating impacts, particularly for women and girls. At the same time, an increasingly coordinated opposition to gender equality, women's rights and SRHR is gaining ground. Restrictions on access to contraception, safe abortion care to the full extent of the law, and comprehensive sexuality education undermine the fundamental human right of every woman and girl to decide freely and responsibly whether and when to have children and to be protected from preventable maternal deaths.

Protecting, respecting and enhancing SRHR is essential for addressing needs, achieving equity, and empowering individuals to make autonomous decisions about their bodies and their futures. This requires successful implementation of evidence-based policies and programmes that improve SRH outcomes for all individuals across the life course. These efforts must be informed by best practices and lessons learned and tailored to local contexts.

Learning from one another is vital. We must focus on what works, acknowledge what does not, continue to innovate and evaluate, and come together with renewed commitment and a collaborative spirit to safeguard and build upon the progress we have achieved to protect and promote SRHR around the world.

The WHO–UNFPA SRHR–UHC Learning by Sharing Portal showcases how countries are expanding access to comprehensive, quality SRH services within UHC, offering practical experiences and insights to guide SRH integration efforts. This magazine presents a rich collection of implementation stories from Chile, Ethiopia, Indonesia, Moldova, Nigeria, Pakistan, Uganda, and Zanzibar (United Republic of Tanzania). These stories, approved by national governments, illustrate health system interventions—from health financing and governance to health workforce strengthening—with particular attention to adolescent SRHR, menstrual health and hygiene, HIV/AIDS, maternal, newborn, and child health, disability inclusion, and access to safe abortion in line with national law and context.

We hope these implementation stories serve as guides for policymakers, health practitioners, civil society and stakeholders around the world, showing how SRHR can be effectively integrated within UHC. Through real-world implementation experiences, these contributions demonstrate practical ways to expand access to essential services and prioritize people's SRHR.

As WHO and UNFPA, we are united in our conviction: there is no universal health coverage without sexual and reproductive health and rights. We each have important, complementary roles. WHO works to strengthen health systems based on the latest evidence and scientific consensus, to provide technical support to countries at all stages of UHC implementation, and to lead in research and standard-setting for SRHR. UNFPA works to translate these global norms and standards into policy and programmes, supporting countries to deliver comprehensive SRH services within a health systems strengthening and primary healthcare approach, promoting gender equality and women's empowerment and ensuring no one is left behind. Together, we combine our expertise to generate evidence and share best practices that inform policy, protect health and advance equity. By acting with urgency and investing in what works, we can ensure that every person, everywhere, has access to the SRH services they need and deserve. The High-Level Meeting on UHC in 2027 will provide a critical opportunity to assess progress against the 2023 Political Declaration on UHC and renew commitments to achieving UHC and SRHR for all. The time to safeguard and accelerate progress is now.

Dr Pascale Allotey

Director, Department of Sexual, Reproductive, Maternal, Child and Adolescent Health and Ageing: Advancing Life Course Health and Reproduction (LHR), WHO, and HRP, the UN's Special Programme in Human Reproduction

Ms. Julia Bunting

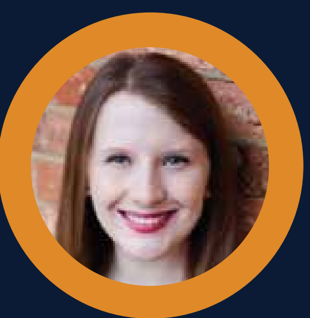
Director, Programme Division, UNFPA

With only five years remaining to achieve the 2030 Sustainable Development Goals (SDGs), the imperative to protect these gains—and close persistent gaps—has never been stronger.

"The LSP is a testament to what's possible when we bring together evidence, experience, and collective ambition. Its stories show that progress on SRHR within UHC is not only possible — it's already happening and gaining momentum, powered by partnerships between policy-makers, communities, and implementers working side by side."

Dr Veloshnee Govender

Scientist, Health Systems, Data, and Digital for Sexual and Reproductive Health (HDS), WHO



"Amid widespread funding cuts, expanding access to essential sexual and reproductive health services can often feel daunting, and at times, even impossible. However, it is possible, and now more than ever, it is vital that we continue to learn from one another and implement cost-effective programmes. Platforms like the Learning by Sharing Portal serve this purpose, playing a crucial role in sharing lessons learned, best practices, and innovative solutions with stakeholders committed to achieving health for all."

Kaitlin Mitchell

Technical Consultant, Learning by Sharing Portal, WHO

About the Sexual and Reproductive Health and Rights and Universal Health Coverage Learning by Sharing Portal

VISIT
www.srhr.org/learn-uhc

WHO & UNFPA: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND UNIVERSAL HEALTH COVERAGE LEARNING BY SHARING PORTAL

Chile

Towards decline in adolescent fertility rate in Chile: a health systems approach

Authors

- Matilde Maddaleno, University of Santiago, Chile, Matilde.maddaleno@usach.cl
- Fernando Gonzalez Escalona, Ministry of Health, Chile
- Joshua Amo Adjei, University of Cape Coast, Ghana
- Erika Vivanco C, University of Santiago, Chile
- Venkatraman Chandra-Mouli, WHO (retired)

60 Second Summary

Adolescent fertility declined by approximately 51% within a decade of the Chilean government making adolescent childbearing a priority intervention agenda in 1995. This progress was achieved through clear leadership and governance, the enactment of adolescent-friendly laws and policies, adequate budgetary provisions for adolescent-friendly health spaces (AFS) complemented by accountability, and participation of young people. The institutionalization of AFS staffed by providers with appropriate skills through continuous professional development, a robust disaggregated system through routine health services data, recurrent national surveys on young people, and prevention of medical stock-outs contributed significantly to the achievements.

Sexual and Reproductive Health & Rights Challenge

Adolescent pregnancy is a social problem exacerbated by inequity and vulnerability with multiple consequences for the adolescent mother, including disruption to schooling, and for the baby, such as increased risk of mortality, morbidity, and undernutrition. Adolescent childbearing is underpinned by multiple social determinants, including inequities in access to sexual and reproductive health (SRH) services.

www.srhr.org/learn-uhc

The intervention in this story—adolescent-friendly spaces (AFS)—including SRHR services, does contribute to the reduction of adolescent pregnancy, while offering adolescents promotive, curative, and rehabilitative health services covering unintended pregnancy, sexually transmitted infections (STIs), mental health, nutrition, and family planning.

Dr. Karima Gholbzouri

WHO Regional Office for the Eastern Mediterranean (EMRO)

IMPLEMENTATION STORY

Chile

60-SECOND SUMMARY

Adolescent fertility declined by approximately 51% within a decade of the Chilean government making adolescent childbearing a priority intervention agenda in 1995. This progress was achieved through clear leadership and governance, the enactment of adolescent-friendly laws and policies, adequate budgetary provisions for adolescent-friendly health spaces (AFS) complemented by accountability, and participation of young people. The institutionalization of AFS staffed by providers with appropriate skills through continuous professional development, a robust disaggregated system through routine health services data, recurrent national surveys on young people, and prevention of medical stock-outs contributed significantly to the achievements.

TOWARDS DECLINE IN ADOLESCENT FERTILITY RATE IN CHILE: A HEALTH SYSTEMS APPROACH

SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE

Adolescent pregnancy is a social problem exacerbated by inequity and vulnerability with multiple consequences for the adolescent mother, including disruption to schooling, and for the baby, such as increased risk of mortality, morbidity, and undernutrition. Adolescent childbearing is underpinned by multiple social determinants, including inequities in access to sexual and reproductive health (SRH) services.

Chile, like many other Latin American countries, has experienced rapid and drastic declines in total fertility rate, though more slowly among adolescent girls. Between 1965 and 2000, adolescent births declined from 86.5 to 61.3/1000. This corresponds with a decline in total fertility rate in Chile from 5.5 children per woman in the early 1970s to approximately 1.6 children per woman in 2018. In 1995, adolescent sexual and reproductive health and rights (ASRHR) became a national priority in Chile, demonstrated by legal and policy reforms aimed at making access to services, particularly contraceptives (including condoms, oral contraceptives, and long-acting reversible contraception [LARC]), universal without economic and socio-legal barriers. Supportive policies were formulated, and a package of interventions was delivered as part of a multi-faceted approach to addressing the sexual, reproductive, mental, and nutritional health of adolescents.

CHILE'S SRHR-UHC INTERVENTION

ASRHR was prioritized through the establishment of institutions, such as the National Adolescent Health Program in the Ministry of Health and Ombudsman Ofice for Children, along with legal reforms including, Law 20, 418 (2010) which dealt with adolescents' access to modern contraceptives, creating an enabling environment for adolescents to access services. The Chilean government strengthened accountability through young people's participation in planning, implementing, monitoring, and evaluating policies and programs. Rather than establishing a parallel system, the approach made full use of existing health services. As part of the National Adolescent and Youth Health Policy 2008, the Ministry of Health created designated spaces within government health facilities, known as adolescent friendly spaces (AFS), to bolster adolescents' access to SRHR services privately and confidentially, with financing from municipal governments to local level facilities. AFS offer adolescents promotive, curative, and rehabilitative health services covering unintended pregnancy, sexually transmitted infections (STIs), mental health, and nutrition. From 2008 –2020, the number of AFS increased from 54 to 348 across the entire country. The Chilean government addressed financial barriers through a universal health insurance program (FONASA) which allows children and adolescents (0–19 years) to access services in both private and public health facilities. The quality of the health workforce was addressed by building the competencies of providers to offer confidential and empathetic services to adolescents and young people.

Health providers received extensive training on providing counselling and contraception services to adolescents. The Chilean Health Information Systems facilitates the timely use of age- and sex-disaggregated data with an additional layer for ethnicity and migration status, covering district, regional, and national levels. The National Survey of Children and Early Adolescents and the National Youth Survey are used to provide insights for local level interventions.

Health providers received extensive training on providing counselling and contraception services to adolescents.

PAHO/WHO

AUTHORS

Matilde Maddaleno, University of Santiago, Chile, Matilde.maddaleno@usach.cl
Fernando Gonzalez Escalona, Ministry of Health, Chile
Joshua Amo Adjei, University of Cape Coast, Ghana
Erika Vivanco C, University of Santiago, Chile
Venkatraman Chandra-Mouli, WHO (retired)

SUCCESS

The entire initiative was led, funded, and executed by the Ministry of Health, and resulted in significant improvements in SRH indicators for adolescents. From 2007–2017, the proportion of births to adolescents reduced by 51%. The fertility rate of adolescents aged 10–19 years declined from approximately 25/1000 in 2005 to 7.8/1000 in 2020. Contraceptive use at sexual debut increased by 30% between 2007 and 2018. However, challenges remain.

More adolescents need access as the coverage of AFS is not yet universal in Chile, and there are outstanding medical barriers to contraceptive use for adolescents. AFS must be strengthened, focusing on rural and disadvantaged communities. Community support and partnerships need to be strengthened, inadequate parent-child communication and social norms around teen sexual behaviors persist. Intersectional disadvantages that drive teen pregnancy exist, which call for multi-sectoral approaches to tackling adolescent childbearing, particularly those being left behind due to geographical and socioeconomic disparities.

Many adolescents and young people do not have access to information and education – Chile must address the gap in counseling and educational interventions, supporting the use of evidence-based, medically accurate, and culturally and age-appropriate sexual health education, incorporating in schools and the use of new technologies to scale.

WHO & UNFPA: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND UNIVERSAL HEALTH COVERAGE LEARNING BY SHARING PORTAL

Pakistan

Rural ambulance service: a public-private transport solution for pregnant women in Punjab, Pakistan

Rural Ambulance Service (RAS) 1034

Authors

Ali Jan Khan, Secretary, Primary & Secondary Healthcare Department, Government of the Punjab, Pakistan. secy.pshealth@punjab.gov.pk

Naeem Majeed, Chief Executive, SPHERE Consulting Pakistan; former Additional Director, IRMNCHN Program, Primary and Secondary Healthcare Department, Punjab, Pakistan. nmajeed@gmail.com

60 Second Summary

Delays in accessing a health facility at the time of delivery can have catastrophic consequences. In May 2017, a rural ambulance service for obstetric and neonatal care was introduced in Punjab province, Pakistan. Accessible by calling a toll-free number, the ambulance service is designed to collect all normal and high-risk pregnant women from their homes at the time of delivery and throughout pregnancy for antenatal complications. Since its launch, the ambulance service has transferred over three million women from their homes to health facilities, around three and a half million women from primary to secondary or tertiary hospitals, and around 10 000 children for urgent referrals. An average of 2800 women are transferred each day across the province.

Sexual and Reproductive Health & Rights Challenge

Maternal mortality rates were estimated to be 178/100 000 live births in Pakistan in 2015. Approximately 30% of maternal deaths in Pakistan are attributable to the second delay in the 'Three Delays Model'; that is the delay in accessing a health facility due to lack of transport. Many women who cannot reach primary care facilities have to deliver at home. In complicated cases, lack of access to emergency obstetric and neonatal care can have catastrophic consequences.

World Health Organization | hrp | UNFPA

www.srhr.org/learn-uhc

Political willingness and alignment with national health priorities are crucial. The Government of Pakistan prioritized maternal health by integrating transport support into its essential health services. Providing a structured transport solution is more sustainable and addresses one of the significant barriers to accessing skilled care.

Dr. Tewodros Seyoum

University of Gondar (UoG), Ethiopian Midwives Association

RURAL AMBULANCE SERVICE: A PUBLIC-PRIVATE TRANSPORT SOLUTION FOR PREGNANT WOMEN IN PUNJAB, PAKISTAN

IMPLEMENTATION STORY

Pakistan

60-SECOND SUMMARY

Delays in accessing a health facility at the time of delivery can have catastrophic consequences. In May 2017, a rural ambulance service for obstetric and neonatal care was introduced in Punjab province, Pakistan. Accessible by calling a toll-free number, the ambulance service is designed to collect all normal and high-risk pregnant women from their homes at the time of delivery, and throughout pregnancy for antenatal complications. Since its launch, the ambulance service has transferred over three million women from their homes to health facilities, around three and a half million women from primary to secondary or tertiary hospitals, and around 10 000 children for urgent referrals. An average of 2800 women are transferred each day across the province.

SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE

Maternal mortality rates were estimated to be 178/100 000 live births in Pakistan in 2015. Approximately 30% of maternal deaths in Pakistan are attributable to the second delay in the 'Three Delays Model', that is the delay in accessing a health facility due to lack of transport. Many women who cannot reach primary care facilities have to deliver at home. In complicated cases, lack of access to emergency obstetric and neonatal care can have catastrophic consequences.

In Punjab, the most populous province of Pakistan, the government scaled up around 700 basic health units in 2015, equipping them with 24-hour basic obstetric care services. By 2017, the number of health units had increased to 1000. However, access to these units for women in rural communities remained challenging.

The Government of Pakistan provided an ambulance service through the health system but due to misuse of vehicles, lack of timely maintenance and lethargy in public sector service delivery, it was ineffective. The government developed and endorsed the national universal health coverage (UHC) benefits package and essential package of health services (EPHS). Punjab province has adapted this benefits package to its context, including the provision of a rural ambulance service for obstetric and neonatal care.

> The ambulance service is designed to collect all normal and high-risk pregnant women from their homes at the time of delivery, and throughout pregnancy for identified antenatal complications.

The ambulance service is designed to collect all normal and high-risk pregnant women from their homes at the time of delivery, and throughout pregnancy for identified antenatal complications. The service can be reached by calling a toll-free number (1034). The ambulance takes the woman to a primary care facility and waits for an initial screening. If the primary care staff feel the need to refer the woman to a higher-level hospital, the same ambulance takes the woman there. If the staff are comfortable conducting a normal vaginal delivery (NVD) at primary care level, the ambulance goes back to its resting point and awaits the next client.

In a new step, the government out-sourced operation of the ambulance service through a unique tripartite arrangement: the central call centre is run and managed by a telecoms operator, the day-to-day vehicle operations are run by a private car rental company, and the technical and financial aspects are managed by the government's Integrated Reproductive, Maternal and Child Health & Nutrition (IRMNCHN) programme.

The call centre is manned by a team of call agents who handle an average of 5000 incoming calls per day. The entire operation is managed through a real-time dashboard that reflects the ambulance locations (tracked through GPS trackers), health facility locations, and other relevant details using Google maps. The call agent's screen shows the ambulances available in a particular area, and the agent can assign the one nearest to the woman's home. Once the ambulance is assigned, the agent identifies the nearest health facility from the same map. A text message is then sent to the driver as well as the client as a confirmation. The text message sent to the client contains the name of the assigned driver, his contact number, and the vehicle's registration number. The text message sent to the driver contains the name of the client and her contact information.

The vehicle operations are overseen by provincial and district level managers hired by the private rental company. The company is also responsible for provision of fuel, drivers, and repair/maintenance of the ambulance. The agreement with the rental company enables the government to track the performance of each vehicle continuously through the dashboard. The key condition of the contract was that "the ambulance engine would turn on within two minutes of a case being assigned to the vehicle, and no excuse for driver or fuel unavailability would be acceptable."

Ali Jan Khan, Secretary, Primary & Secondary Healthcare Department, Government of the Punjab, Pakistan. secy.pshealth@punjab.gov.pk
Naeem Majeed, Chief Executive, SPHERE Consulting Pakistan; former Additional Director, IRMNCHN Program, Primary and Secondary Healthcare Department, Punjab, Pakistan, nmajeed@gmail.com

SRHR-UHC OUTCOMES

Rural Ambulance Service (RAS) 1034, BHU Bhamba Kalan, Kasur

SUCCESS

Since its launch in May 2017, the ambulance service has transferred over three million women from their homes to health facilities, around three and a half million women from primary to secondary or tertiary hospitals, and around 10000 children, aged under five years, for urgent referrals. An average of 2800 women are transferred each day across the province, including public holidays. It has been estimated that at least half of the 500 000 emergency referrals to secondary and tertiary care hospitals have prevented severe morbidity and maternal mortality. The cost per transfer for an average case is approximately US$ 10–15. In the past, government-run ambulance systems were cost-intensive and heavily misused by the local authorities. Centralizing the system has helped prevent misuse of the service.

The success of the rural ambulance service in Punjab, implemented through an outsourced model, is evident from the reduction in maternal mortality in Punjab to 157/100 000 live births in 2019, increase in skilled birth attendance, and improvement in timeliness of access to maternal care services in rural areas. All three million women who have used the service would have had to arrange transport on their own if the ambulance was not available.

Locating addresses in rural areas is a challenge, as streets and house numbers are often unmapped, and so most of the clients and their caretakers are unable to provide exact addresses. This is being addressed through exchange of mobile phone numbers of ambulance drivers and clients/caretakers through automated text messages sent out to both parties once a case is assigned on the dashboard, so they can call and ask for the exact location.

WHO & UNFPA: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND UNIVERSAL HEALTH COVERAGE LEARNING BY SHARING PORTAL

Ethiopia

Menstrual health programming as a foundation for adolescent sexual and reproductive health and rights in Ethiopia

Tricia Petruney, Pathfinder

Authors

- Masresha Soressa, Pathfinder International, Ethiopia, msroessa@pathfinder.org
- Abiy Hiruy, Pathfinder International, Ethiopia.

60 Second Summary

Girls in Ethiopia often reach puberty without receiving adequate, accurate, or timely information on menstruation, including how to maintain menstrual health and its links to pregnancy. Pathfinder International implemented a menstrual health and hygiene intervention in two regions of Ethiopia, including weekly sessions on menstruation for adolescent boys, girls and their caregivers and training for health extension workers and school staff on menstrual hygiene management. Girls who attended the sessions felt positive after learning how to make reusable pads and managing their periods. Boys were interested in understanding the biological purpose of menstruation and the experience. Health extension workers and school staff raised funds to make necessary changes to better support menstruating girls in schools.

Sexual and Reproductive Health & Rights Challenge

In Ethiopia, coverage of reproductive health information and services remains low with a large gap between coverage rates and the universal health coverage (UHC) targets laid out in the country's 2021–2025 Health Sector Transformation Plan (HSTP). Over one in five Ethiopian adolescents has an unmet need for family planning (FP). Sociocultural barriers to menstruation, adolescent and youth sexual and reproductive health (AYSRH), and abortion information and services continue to be pervasive, with menstruation remaining taboo for much of the population. Access to water, sanitation and hygiene is crucial for girls and women to manage menstruation effectively and reduce the risk of infections.

www.srhr.org/learn-uhc

Menstrual health is critical for adolescent health and gender equality in its own right, and we know that many girls experience high unmet menstrual needs, including for accurate and timely information. Menstrual health may also be an important foundation for broader sexual and reproductive health, with early menstrual experiences potentially shaping girls' agency and behaviours related to contraception and pregnancy planning.

Dr. Elissa Kennedy

Burnet Institute

MENSTRUAL HEALTH PROGRAMMING AS A FOUNDATION FOR ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN ETHIOPIA

60-SECOND SUMMARY

Girls in Ethiopia often reach puberty without receiving adequate, accurate, or timely information on menstruation, including how to maintain menstrual health and its links to pregnancy. Pathfinder International implemented a menstrual health and hygiene intervention in two regions of Ethiopia, including weekly sessions on menstruation for adolescent boys, girls and their caregivers and training for health extension workers and school staff on menstrual hygiene management. Girls who attended the sessions felt positive after learning how to make reusable pads and managing their periods. Boys were interested in understanding the biological purpose of menstruation and the experience. Health extension workers and school staff raised funds to make necessary changes to better support menstruating girls in schools.

SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE

In Ethiopia, coverage of reproductive health information and services remains low with a large gap between coverage rates and the universal health coverage (UHC) targets laid out in the country's 2021–2025 Health Sector Transformation Plan (HSTP). Over one in five Ethiopian adolescents has an unmet need for family planning (FP). Sociocultural barriers to menstruation, adolescent and youth sexual and reproductive health (AYSRH), and abortion information and services continue to be pervasive, with menstruation remaining taboo for much of the population. Access to water, sanitation and hygiene is crucial for girls and women to manage menstruation effectively and reduce the risk of infections.

In Ethiopia, girls often reach puberty without receiving adequate, accurate, or timely information on menstruation, including how to maintain menstrual health and its links to pregnancy. Many girls experience stigma, shame, school absenteeism, and unintended pregnancy due to this lack of knowledge. While attention to menstrual health and hygiene (MHH) has grown across several sectors in recent years, it is not yet adequately recognized and addressed as both a barrier to and potential enabler of contraceptive use among adolescents and youth. Learning about menstruation during very early adolescence is critical for correctly understanding fertility and conception, and later making informed decisions about pregnancy and FP.

ETHIOPIA'S SRHR-UHC INTERVENTION

> The long-term goal of the programme is better contraception outcomes for youth by enhancing adolescent girl's agency.

Act With Her (AWH) is a five-year programme in Ethiopia, led by Pathfinder International in partnership with CARE International and the Government of Ethiopia, with funding from the Bill & Melinda Gates Foundation. It aims to forge health, education, economic, and social pathways that adolescent girls [10–19 years] need to thrive into young adulthood. The programme engages young adolescent girls, boys, and their caregivers in group sessions over 10 months. The long-term goal of the programme is better contraception outcomes for youth by enhancing adolescent girl's agency. MHH establishment in schools is used as an entry point for adolescent girls on matters of sexuality and reproductive health decisions.

Pathfinder implemented the MHH component of AWH in two regions of Ethiopia – six woredas in South Gondar, Amhara, and four woredas in the previous Southern Nations Nationalities and Peoples (SNNP) region. AWH supported 52105 young adolescents (29883 girls and 22222 boys) aged 10–14 years and their caregivers with one group session per week over 10 months for a total of 40 sessions, including multiple modules on menstruation (biological facts, relationship to conception) and related issues (reducing stigma, making reusable pads).

Furthermore, 640 health extension workers and education staff from 128 schools in Amhara and SNNP underwent a menstrual health management (MHM) training developed by Pathfinder, the government, and UNICEF. The trainees were selected using criteria for their MHM experiences and their roles in schools and communities. The goal is for schools to become "MHM Model Schools", fulfilling minimum site requirements, including gender-separate toilets, washing and waste disposal stations, and educational materials, and also achieving a reduction in the number of girls dropping out due to menstruation. Project staff analyzed DHIS2 programme data from 2019–2023 and qualitative feedback collected from a range of participants (adolescents, caregivers, communities, and school stakeholders) was analyzed to identify both quantitative outputs as well as trends and themes on effectiveness.

AUTHORS

Masresha Soressa, former Act With Her Project Technical Advisor, Pathfinder International, Ethiopia, masre78@gmail.com
Abiy Hiruy, Pathfinder International, Ethiopia.

SRHR-UHC OUTCOMES

Tricia Petruney, Pathfinder

Pathfinder Act With Her staff, school staff, and health extension workers stand in the entryway to the new menstrual health management building of the Yewiha Midir Primary School

SUCCESS

According to AWH project data, over 85% girls who attended weekly sessions were interested in learning about and improving their current and future menstrual health. Girls reported feeling happy after learning how to make reusable pads and how to better manage their periods (including while at school) and felt less ashamed. Even in the most culturally conservative areas, as the topic was also included in boys', caregivers', and community-wide activities, data revealed (70%) an unexpected level of interest in open dialogue and calls for change among boys, fathers, male school directors and teachers, health workers, and community and religious leaders. A common theme among boys who participated was a strong appreciation for understanding its biological purpose and the menstruation experience of their sisters and mothers. After undergoing the MHM training, 484 health extension workers and school staff proactively raised funds to make the changes necessary to meet the minimum standards in their schools and to better support menstruating girls. Ninety percent (115/128) of supported schools established a dedicated MHM room, often by re-purposing an existing space. School staff also raised their own funds for purchasing basic materials and equipping sanitary and hygienic stations. From October 2020–March 2023, over 31263 girls used the rooms for pad changing, washing, resting, and receiving counselling. Substandard water infrastructure remains a complicated challenge for most of the school sites and is diffcult to address within health and wellness initiatives alone.

It shows that it’s possible to engage religious leaders with topics such as SRH and women's rights and achieve positive outcomes. It exemplifies a process of working together and incorporating health messages with religious narratives to better adapt to the context and, consequently, achieve better results.

Mariana Rodo

Médecins Sans Frontières

www.srhr.org/learn-uhc

ENGAGING RELIGIOUS LEADERS AS CHANGE AGENTS TO STRENGTHEN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

IMPLEMENTATION STORY

Nigeria

60-SECOND SUMMARY

In Nigeria, religious leaders play an important role in community health, including sharing information on sexual and reproductive health and rights (SRHR). Plan International worked with religious leaders, the government, and local partners to use Islamic teachings to help dismantle barriers to SRHR in Sokoto State, Nigeria. Religious scholars and Plan International co-created a gender integrated manual, 'Islamic perspectives on maternal, newborn and child health issues' to provide guidance on SRHR to Islamic leaders. The manual was used in 93 activities, including community congregations, Friday sermons in mosques, and radio talk shows. Engaging religious leaders as change-makers in their communities can make a positive difference when actualizing social change.

SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE

Adolescent girls and young women aged 10–24 years comprise 30% of the female population of Nigeria. Policies and legal instruments designed to protect young people's sexual and reproductive health and rights (SRHR), including the National Health Act (2014) and the National Policy on the Health and Development of Adolescents and Young People in Nigeria (2020–2024), have not always translated into improved outcomes. The adolescent (15–19 years) birth rate is 102 per 1000, contraceptive prevalence is 18%, and 30% of the population is married before age 18 years.

Religion is an important part of the cultural fabric of communities, informing ideologies, ethical behaviors, and decision-making. In Sokoto state, Nigeria, religious leaders and institutions strongly influence family, community and societal norms and values. Religious leaders provide moral and spiritual guidance to members of their congregations, including on gender and family relations, and act as gatekeepers, trusted advisors, and providers of information on SRHR. They can also act as barriers to interventions, particularly, on strengthening the agency of women and girls to access sexual and reproductive health (SRH) services.

NIGERIA'S SRHR-UHC INTERVENTION

As part of the Strengthening Health Outcomes for Women and Children (SHOW) project (2016–2022), Plan International worked with religious leaders in Sokoto State to use Islamic teachings to dismantle barriers to SRHR, in collaboration with government and local partners. The interventions began with sensitization meetings from January–March 2017 with over 92 religious leaders and members of the Central Shura (the committee of nationally renowned religious leaders), to gain strategic support to work with a wider network of religious leaders.

In consultation with the Shura, a 4-day workshop was conducted in April 2017 with 64 religious leaders (10 female), representing various sects of Islamic thought and 23 local government areas. The proceedings led to a compilation of references to gender in the Quran, Hadith, and scriptures, which were used to encourage religious leaders to shed misperceptions and promote healthy SRH behaviors among male partners, parents, health workers and other service providers to strengthen SRHR. From these discussions, the group of leading religious scholars and Plan International co-created a gender integrated manual, 'Islamic perspectives on maternal, newborn and child health issues' to provide additional guidance on SRHR for Islamic leaders. The manual covered:

1. Islamic perspectives on (i) maternal, newborn and child health (MNCH) issues, and (ii) women's rights, including decision-making power and freedom from violence.
2. Men's engagement in SRH.
3. Guidance on medical care for MNCH, including family planning.

The manual was endorsed for onward use by religious leaders who participated in its development at a 2-day validation meeting in January 2018. From February–June 2018, 64 religious scholars led dialogues on the manual with 690 traditional and religious leaders (276 female, 414 male) throughout the State. The manual was jointly launched on 2 April 2019, with participation from the State Ministries of Health, Women and Children Affairs, Religious Affairs, and the Sokoto State Primary Health Care Development Agency.

In consultation with the Shura, a 4-day workshop was conducted in April 2017 with 64 religious leaders (10 female), representing various sects of Islamic thought and 23 local government areas.

Aaliya Bibi, Senior Health Advisor, Plan International, Canada abibi@plancanada.ca
Ajita Vidyarthi, Senior Gender Equality and Inclusion Advisor, Plan International, Canada

SRHR-UHC OUTCOMES

Dr Muhamamd A Inname, Sokoto State Commissioner of Health; Professor Sambo Junaidu, Chairman Religious Affairs, Sokoto Sultanate Council; Sheikh (Dr) Mustapha Sidi, Chief Imam of Ali Akilu Jummat Mosque, Sokoto; and other dignitaries at the launching of the 'Islamic Perspectives on MNCH Issues" on 2nd April 2019.

OUTCOMES

The manual, 'Islamic Perspectives on maternal, newborn and child health issues', was used by religious leaders in 93 community activities, including community congregations, Friday sermons in mosques, and radio talk shows.

"I use the manual to advise and convince my followers and other religious leaders on topics that are seemingly difficult to understand such as child spacing and the importance of women delivering in the hospital." [Male religious leader]

Community sensitization activities led by religious leaders encouraged women of reproductive age (WRA) and their male partners to engage in health seeking behaviors. The proportion of WRA seeking antenatal care (ANC) increased from 51% at baseline in July 2016 to 78% at endline in June 2021, skilled birth attendance increased from 24% to 57% and percentage of WRA receiving postnatal care (PNC) within two days of childbirth increased from 14% to 26%, between the same time points. Improvements were also reported in awareness of modern family planning methods, from 52% at baseline to 94% at endline for adolescent mothers (15–19 years of age), and from 58% to 97% for adult mothers (20–49 years of age). An increase in WRA currently using modern family planning methods from 4% at baseline to 26% at endline for adolescent women, and from 5% at baseline to 32% at endline for adult women, was observed.

Women's participation in community-level decision-making increased from 29% at baseline to 57% at endline and Community Health Committee leadership positions held by women increased from 14% to 23% at endline. The strategy also proved successful for men's engagement through the continuum of care, with the average level of support provided by male family members for utilization of MNCH/SRH services by female family members increasing from 35.8% at baseline to 57.2% at endline. Despite these successes, there was limited uptake of some gender equality messages, such as on zero tolerance of early marriage.

WHO & UNFPA: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND UNIVERSAL HEALTH COVERAGE LEARNING BY SHARING PORTAL

Indonesia

Decentralizing HIV care and training towards ending HIV in Indonesia

Puskesmas Kotabumi II

Authors

- Yusuf Aulia Rahman, RSUD Abdul Moeloek Provinsi Lampung, Indonesia, y.auliarahman@gmail.com
- Otta Nur Kirana, Lampung Provincial Health Office, Indonesia
- Lukman Pura, Indonesian Society of Internal Medicine Specialist, Indonesia

60 Second Summary

Lampung province, Indonesia, had insufficient HIV care services to meet the needs of its population. In 2017, Lampung Provincial Hospital and Lampung Health Office began collaborating to establish the hospital as a centre of excellence for HIV care, providing health services and training for health workers to establish HIV care centres across the province. As of September 2022, there were 201 HIV care centres across 15 municipalities in Lampung province, compared with only two centres in the province in 2015. This expansion brought HIV diagnostics and ART services closer to patients, resulting in greater numbers of patients being diagnosed with HIV, enrolled on ART, and adhering to their treatment plans.

Sexual and Reproductive Health & Rights Challenge

Indonesia has been making efforts to achieve the UNAIDS 95-95-95 targets for HIV testing, treatment, and viral load suppression throughout its entire territory. The national HIV elimination programme has been implemented in all 38 provinces of the country, including 13000 islands that face unique geographical, cultural, and socioeconomic challenges. By the end of 2022, 81% of people living with HIV in Indonesia knew their HIV status, 42% of those who knew their HIV status were receiving antiretroviral treatment, and 19% of those receiving treatment were virally suppressed. In 2015, Lampung province, with a population of 9 million and an HIV prevalence rate of 0.4%, had only two healthcare services located in the capital city of Bandar Lampung providing

The intervention prioritises sustainability by ensuring that trained staff are not only retained but also continuously educated. This focus on ongoing training addresses a common challenge in many settings, and this project has been successful in overcoming it.

Dr. Goran Zangana

Health Systems Global

www.srhr.org/learn-uhc

DECENTRALIZING HIV CARE AND TRAINING TOWARDS ENDING HIV IN INDONESIA

IMPLEMENTATION STORY

Indonesia

60-SECOND SUMMARY

Lampung province, Indonesia, had insufficient HIV care services to meet the needs of its population. In 2017, Lampung Provincial Hospital and Lampung Health Office began collaborating to establish the hospital as a centre of excellence for HIV care, providing health services and training for health workers to establish HIV care centres across the province. As of September 2022, there were 201 HIV care centres across 15 municipalities in Lampung province, compared with only two centres in the province in 2015. This expansion brought HIV diagnostics and ART services closer to patients, resulting in greater numbers of patients being diagnosed with HIV, enrolled on ART, and adhering to their treatment plans.

SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE

Indonesia has been making efforts to achieve the UNAIDS 95-95-95 targets for HIV testing, treatment, and viral load suppression throughout its entire territory. The national HIV elimination programme has been implemented in all 38 provinces of the country, including 13000 islands that face unique geographical, cultural, and socioeconomic challenges. By the end of 2022, 81% of people living with HIV in Indonesia knew their HIV status, 42% of those who knew their HIV status were receiving antiretroviral treatment, and 19% of those receiving treatment were virally suppressed. In 2015, Lampung province, with a population of 9 million and an HIV prevalence rate of 0.4%, had only two healthcare services located in the capital city of Bandar Lampung providing HIV treatment. This proved insufficient to identify and manage the estimated 36000 people living with HIV (PLHIV) in the population. Expanding the availability of peripheral HIV care services would improve access to HIV diagnosis and antiretroviral (ARV) treatment and alleviate workload burden on existing services. Moreover, bringing HIV care closer to the affected population would also reduce out-of-pocket expenses for referred patients seeking care.

INDONESIA SRHR-UHC INTERVENTION

The process of sustainably increasing the number of HIV care centres in Lampung province began in 2017 with Lampung Provincial Hospital and Lampung Health Office working together to develop a comprehensive HIV care service. The first step focused on establishing the provincial hospital as a centre of excellence for HIV care, serving as both a medical service provider and a training ground for health workers. The hospital provided staff members for the HIV care team who received training facilitated by the health office in collaboration with the Ministry of Health (MoH).

The training encompassed both in-class lessons and hands-on experience. This approach enabled team members to understand complex cases and increase confidence when they returned to their respective locations. After completing training, the hospital management ensured the maintenance of the team by issuing a regulation anchoring the multidisciplinary team to stay in the service, while the health office facilitated their work by providing uninterrupted supplies of ARV medication and other necessary resources as mandated by the MoH.

To maintain and improve the quality of HIV care services across the province, simultaneous training of peripheral healthcare services to establish their own HIV care teams took place. This involved collaboration with local NGOs specializing in peer support for PLHIV and outreach programmes. Additionally, province-wide HIV care support and treatment (CST) trainings were conducted for community health services and municipal hospitals to establish their own HIV care teams. Local NGOs played a crucial role in identifying cases among key populations and providing support to newly diagnosed HIV patients.

> To maintain and improve the quality of HIV care services across the province, simultaneous training of peripheral healthcare services to establish their own HIV care teams took place.

Yusuf Aulia Rahman, RSUD Abdul Moeloek Provinsi Lampung, Indonesia, y.auliarahman@gmail.com
Otta Nur Kirana, Lampung Provincial Health Office, Indonesia
Lukman Pura, Indonesian Society of Internal Medicine Specialist, Indonesia

SRHR-UHC OUTCOMES

OUTCOMES

As of September 2022, there were 201 HIV care centres located across 15 municipalities in Lampung province, compared with two centres in the province in 2015. This expansion brought HIV diagnostics and ART services closer to patients, resulting in greater numbers of patients being diagnosed with HIV (from 241 in 2015 to 730 in 2022), enrolled on ART and adhering to their treatment plans. Furthermore, this expansion effectively distributed the workload from the provincial hospital to peripheral HIV care centres, leading to a reduction in the number of new cases and cases lost-to-follow-up at the hospital.

Apart from lack of funding from the local government, high stigma and discrimination towards PLHIV and high turnover rate of team members without adequate replacement, especially in peripheral HIV services, posed significant challenges to establishing new HIV care facilities and maintaining operations. To address these challenges, social media platforms like WhatsApp were used to encourage newly recruited HIV care team members to share concerns, doubts, and obstacles encountered while referring complicated cases, such as advanced stages of HIV infection and PLHIV with obstetric emergencies. This two-way communication approach helps reduce stigma associated with handling HIV cases beyond perceived capability and boosts team members' confidence to work within their capacity, preventing them from feeling isolated or unsupported.

High turnover among HIV care team members is an inevitable threat to team sustainability. The main idea of decentralizing health training in this context was to establish provincial hospitals as accessible learning grounds for every team. Previously, teams were required to travel to the national capital city, Jakarta, for HIV care training but now they only needed to travel to the provincial capital. Moreover, accessing this learning site did not depend on external funding since the teams were only required to provide accommodation within the province. This made the training more sustainable and feasible for teams involved.

WHO & UNFPA: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND UNIVERSAL HEALTH COVERAGE LEARNING BY SHARING PORTAL

Zanzibar

Reaching women left behind: transforming post-abortion care in Zanzibar

ZAFAYCO, Tanzania

Authors

- Anna Temba, EngenderHealth, Tanzania, atemba@engenderhealth.org
- Musa Shilangale, EngenderHealth, Tanzania
- Deus Ngerangera, EngenderHealth, Tanzania
- Greysmo Mutashobya, EngenderHealth, Tanzania
- Moke Magoma, EngenderHealth, Tanzania
- Zuwena Salim, ZANA, Zanzibar
- Abdallah Abeid, ZAFAYCO, Zanzibar
- Kate O'Connell, EngenderHealth, Uganda
- Malayah Harper, EngenderHealth, United States

60 Second Summary

Lack of policy, planning, budgeting, and an operationally supportive environment for post-abortion care (PAC) and comprehensive abortion care (CAC) limit the attainment of universal coverage of these services in Tanzania. EngenderHealth's two-phase Expand PAC project aimed to support the realization of universal health coverage by strengthening the enabling policy and operational environments for provision of high-quality PAC and CAC within existing law in mainland Tanzania and Zanzibar. PAC is now included in the essential package for emergency obstetric care and must be budgeted for in district plans in Zanzibar. It is crucial to leverage opportunities and advance advocacy efforts in the context of restrictive abortion laws in Tanzania, including Zanzibar.

www.srhr.org/learn-uhc

> It is a prime example of how well-planned parallel programs, particularly those that supplement government efforts, can temporarily address and strengthen gaps in provision and access to services/goods and later successfully transition to governments supported by policy and operations.

Terry Gachie

Love Matters Kenya

REACHING WOMEN LEFT BEHIND: TRANSFORMING POST-ABORTION CARE IN ZANZIBAR

IMPLEMENTATION STORY

Zanzibar

60-SECOND SUMMARY

Lack of policy, planning, budgeting, and an operationally supportive environment for post-abortion care (PAC) and comprehensive abortion care (CAC) limit the attainment of universal coverage of these services in Tanzania. EngenderHealth's two-phase Expand PAC project aimed to support the realization of universal health coverage by strengthening the enabling, policy and operational environments for provision of high-quality PAC and CAC, within existing law, in mainland Tanzania and Zanzibar. PAC is now included in the essential package for emergency obstetric care and must be budgeted for in district plans in Zanzibar. It is crucial to leverage opportunities and advance advocacy efforts in the context of restrictive abortion laws in Tanzania, including Zanzibar.

SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE

In 2023, Tanzania enacted a landmark Universal Health Insurance Act, mandating health insurance coverage for all citizens. Sexual and reproductive health and rights (SRHR) services, including post-abortion care (PAC), are offered free of charge to the lowest level of public health facilities – dispensaries – shielding women from catastrophic financial expenditure. While PAC is legally permitted in mainland Tanzania and Zanzibar, comprehensive abortion care (CAC) and induced abortion is restricted under the penal code, and only permissible under certain conditions, for example when the life of the mother is in danger. In Zanzibar, complications from abortion contribute approximately 16% of the 166 maternal deaths per 100 000 live births. The restrictive legal environment coupled with stigma and discrimination and a weak operational environment to program for PAC and CAC adversely affect government efforts to reduce maternal mortality. In Zanzibar, while PAC is included in the 2021 minimum intervention service package for community health volunteers, the lack of policy, planning, budgeting, and operationally supportive environment for PAC and CAC limit the attainment of universal coverage of these services and present serious challenges for women trying to access them.

ZANZIBAR'S POST-ABORTION CARE INTERVENTION

EngenderHealth's Expand PAC project aimed to support the realization of universal health coverage (UHC) by strengthening the enabling, policy, and operational environments for provision of high-quality PAC and CAC, within existing law, in mainland Tanzania and Zanzibar.

EngenderHealth's Expand PAC project aimed to support the realization of universal health coverage (UHC) by strengthening the enabling, policy, and operational environments for provision of high-quality PAC and CAC, within existing law, in mainland Tanzania and Zanzibar. The project was implemented in two phases.

Phase one, from 2016–2019, focused on increasing access to quality, affordable PAC services. During this phase, health and care worker capacity was strengthened in line with WHO's abortion care guideline, including training and supportive supervision for nurses. Existing equipment and supplies were renovated, and procurement supported. Supply chain management was strengthened, including for misoprostol, through advocacy on fund allocation for commodities and increasing accountability through a commodity security technical working group. Use of data for decision-making was facilitated by routine data quality assessments and identification of data quality champions to support PAC providers and managers on data capture and use. EngenderHealth worked with the Zanzibar Ministry of Health's (ZMOH) health management information systems (HMIS) unit to develop a facility-specific dashboard for PAC in the national DHIS 2 system, which was made available to specific health providers to routinely review performance and make changes. Standard operating procedures (SOPs) for PAC data capture, analysis, and use were developed and a rollout plan for the replication of best practices on data use developed with the ZMOH. Community health workers were trained to provide information, address myths and stigma around PAC.

In phase two, from 2020–2022, EngenderHealth worked with the ZMOH, providing technical and financial assistance, to co-design and jointly implement transitioning of the project to the Government. National and international NGOs, and local abortion champions were instrumental in localizing project design, supporting implementation, identifying areas of leverage, and facilitating a smooth transition during the project's end stage. EngenderHealth engaged and strengthened the capacity of the Zanzibar Fighting Against Youth Challenges Organization (ZAFAYCO) and Zanzibar Nurses Association (ZANA) to localize efforts for sustainable amplification of the CAC/PAC agenda.

Expand PAC employed a six-step process to design, implement, evaluate, and transition project interventions (Figure 1). Each step involved EngenderHealth and ZMOH jointly monitoring alignment with the government's strategy and core objectives and responsiveness to the needs of local stakeholders.

Figure 1

JOINT MONITORING

IDENTIFY PROBLEMS
Conduct Situation Analysis
Conduct Stakeholder Mapping

SET AGENDA
Co-Design Agenda
Consult Government
Jointly Develop Plan

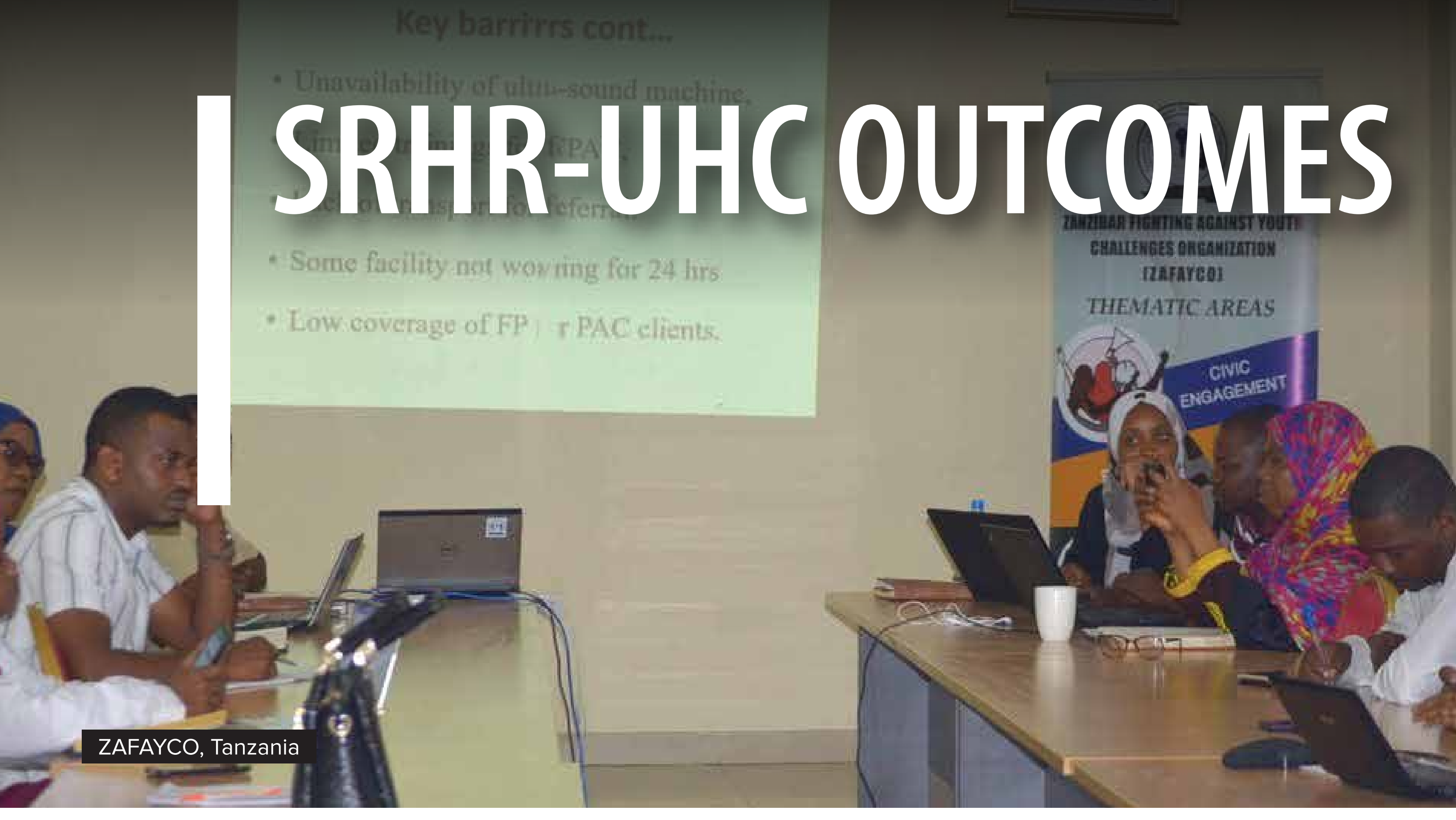
LOCALIZE EFFORTS
Strengthen Local Capacity
Mobilize Champions
Establish Forums and Systems

PLAN IMPLEMENTATION
Support Government Ownership
Establish Committee for Inclusivity
Engage International and Local Partners
Engage Local Champions

TRACK RESULTS
Document Findings
Plan Replication
Share Learning

COMPLETE TRANSITION
Convene Transition Committee
Jointly Plan Transition
Complete Closeout Process

SRHR-UHC OUTCOMES


ZAFAYCO, Tanzania

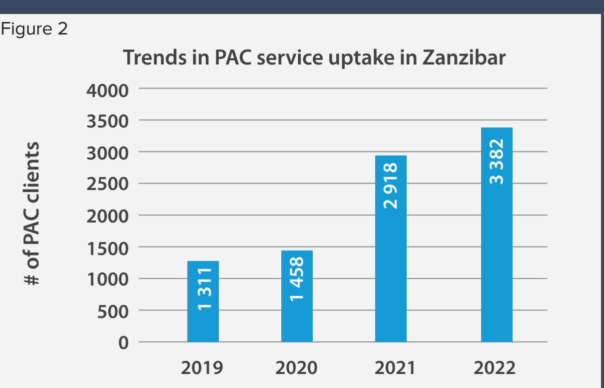
OUTCOMES

ExpandPAC applied process innovation to support the development and review of PAC guidelines and a minimum service delivery package for PAC to inform planning and budgeting. PAC is now included in the essential package for emergency obstetric care and must be budgeted for in district plans. ZANA sustained advocacy and capacity building of healthcare providers and ZAFAYCO mobilized communities through dialogues and social media.

The project created a network of 20 PAC champions, supported establishment of a PAC social pact – a coalition of like-minded organizations and champions – and reproductive maternal newborn child and adolescent health and PAC technical working group. These forums provided safe spaces for discussion about strategies to improve access and utilization of PAC/CAC services within the provision of law. The project supported establishment of an electronic partners' coordination portal so the ZMOH can now better coordinate partners implementing various other projects in Zanzibar. Additionally, the project supported upgrading the Zanzibar integrated human resource information system to include a training module for systematic planning and monitoring of in-service healthcare providers, ensuring providers receive the training they need without repeating trainings, thus improving cost efficiencies.

Uptake of PAC in Zanzibar increased from 1458 clients in 2020 to 3382 in 2022 with 79% opting for post-abortion family planning. Figure 2 illustrates trends in PAC service uptake in Zanzibar as reported within the Zanzibar DHIS2 system.

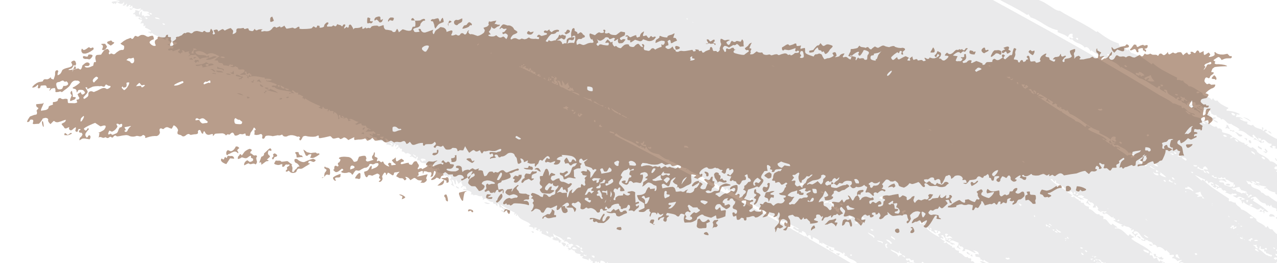
Figure 2



The restrictiveness of CAC legislation and laws continues to pose a significant barrier on supply and demand sides. While misoprostol stocks are currently at an optimal level in Zanzibar, the financial resources allocated for PAC and CAC even within the legal framework are insufficient. Moreover, existing sociocultural norms and religious beliefs in Zanzibar impede efforts to increase the use of PAC services. Challenges exist beyond the life of the project, specifically maintaining the quality of respectful PAC/CAC services.

AUTHORS

Anna Temba, EngenderHealth, Tanzania, atemba@engenderhealth.org
Musa Shilangale, EngenderHealth, Tanzania
Deus Ngerangera, EngenderHealth, Tanzania
Greysmo Mutashobya, EngenderHealth, Tanzania
Moke Magoma, EngenderHealth, Tanzania
Zuwena Salim, ZANA, Zanzibar
Abdallah Abeid, ZAFAYCO, Zanzibar
Kate O'Connell, EngenderHealth, Uganda
Malayah Harper, EngenderHealth, United States



There is **NO UHC** without **SRHR**!

VISIT www.srhr.org/learn-uhc

WHO & UNFPA: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND UNIVERSAL HEALTH COVERAGE LEARNING BY SHARING PORTAL

Moldova

A systems approach to advancing adolescent sexual and reproductive health and rights in Moldova

YK volunteers in process of peer-education sessions in schools and promotion of YFHS among peers, 2023

Authors

- Galina Lesco, Obstetrician-Gynaecologist, Head of Resourse Centre at the National Level in Youth Friendly Health Services NEOVITA, Moldova, galina.lesco@gmail.com
- Joshua Amo Adjei, Cape Coast University, Ghana
- Venkatraman Chandra-Mouli, Independent adolescent sexual and reproductive health and rights learner, communicator, advisor, teacher, and supporter of advocacy/research/action, Switzerland

60 Second Summary

Adolescents and youth in Moldova were particularly affected by the period of instability following the collapse of the Soviet Union in the 1990s. The Government of Moldova instituted several policy and legal initiatives to expand access to adolescent sexual and reproductive health and rights (ASRHR) services from the early 2000s onwards. The strong legislative and policy environment, coupled with strengthening data and interventions aimed at increasing service delivery, have led to improved ASRHR outcomes in the last decade, including increasing use of contraceptives and decreasing teens pregnancy rate. Adolescents played a crucial role in designing and delivering the interventions.

Sexual and Reproductive Health & Rights Challenge

Moldova has a universal health care system that aims to provide access to basic health services for all its citizens. The period following the dissolution of the Soviet Union in the 1990s led to significant social, economic, and health system disruptions in Moldova. Adolescents and youth were particularly affected with increases in sexually transmitted infections and early and unintended pregnancy. Between 1994 and 1996, one in five births were to mothers under the age of 20 years.

www.srhr.org/learn-uhc

Donor support can initiate innovation, but embedding youth-friendly services into national budgets, health insurance schemes, and pre-service training systems ensures long-term sustainability. Moldova's experience underscores the importance of national commitment for lasting results.

Dr. Ibrahim Banaru

Africa Rennaissance (AfriWon) World Organization of Family Doctors (WONCA)

Moldova's network of Youth Friendly Health Centers, supported by outreach and digital counseling, exemplifies how integrated services can effectively reach diverse adolescent populations, including rural and vulnerable youth.

Jihan Salad

AlignMNH Steering Committee

A SYSTEMS APPROACH TO ADVANCING ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS IN MOLDOVA

IMPLEMENTATION STORY

Moldova

60-SECOND SUMMARY

Adolescents and youth in Moldova were particularly affected by the period of instability following the collapse of the Soviet Union in the 1990s. The Government of Moldova instituted several policy and legal initiatives to expand access to adolescent sexual and reproductive health and rights (ASRHR) services from the early 2000s onwards. The strong legislative and policy environment, coupled with strengthening data and interventions aimed at increasing service delivery, have led to improved ASRHR outcomes in the last decade, including increasing use of contraceptives and decreasing teens pregnancy rate. Adolescents played a crucial role in designing and delivering the interventions.

SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE

Moldova has a universal health care system that aims to provide access to basic health services for all its citizens. The period following the dissolution of the Soviet Union in the 1990s led to significant social, economic, and health system disruptions in Moldova. Adolescents and youth were particularly affected with increases in sexually transmitted infections and early and unintended pregnancy. Between 1994 and 1996, one in five births were to mothers under the age of 20 years.

The incidence of HIV among adolescents in Moldova has been rising and adolescents aged 15–19 years accounted for 14.4% of HIV-infected people in 2003. Since the early 2000s, the Ministry of Health of Moldova prioritized re-orienting the public health system, including prioritizing meeting ASRHR needs. The country introduced a mandatory health insurance (MHI) system in 2004 to improve the effciency and transparency of health financing, prioritizing primary care. Approximately 88% of the population was covered by mandatory health insurance in 2021.

MOLDOVA'S SRHR-UHC INTERVENTION

To address ASRHR issues, the Republic of Moldova developed and implemented youth friendly health services (YFHS).

Leadership and governance: Adolescent health and access to YFHS was a priority in the National Strategy for Reproductive Health 2005-2015, National Health Policy 2007–2021, and continues to be a priority for the National Health Strategy 2030. According to health law and reproductive health law, adolescents can access health services, including SRH services, without parental consent from age 16 years, or younger in cases where parents cannot be reached, and life-saving services are needed.

Health system financing: Health insurance for children, students, and pregnant women is paid for by the state. A basic package of services is available free for all. The national health insurance company has been funding Youth Friendly Health Centres (YFHC) since 2008 ensuring free access for all young people aged 10–24 years and for vulnerable youth up to 35 years of age.

Service delivery: YFHS are provided by a network of 41 YFHC – Youth Klinics (YK) in public primary health care institutions in all municipalities and districts of Moldova, based on Youth Friendly Health Services Quality Standards with a special focus on rural youth, vulnerable and at-risk adolescents. Services include outreach (YK Mobile) and online counselling (YK Support line).

Health workforce: Adolescent healthcare training courses/modules were incorporated into preservice curricula at the medical university and nursing and midwifery schools. Collaborative learning sessions are organized regularly by all YFHC/YKs.

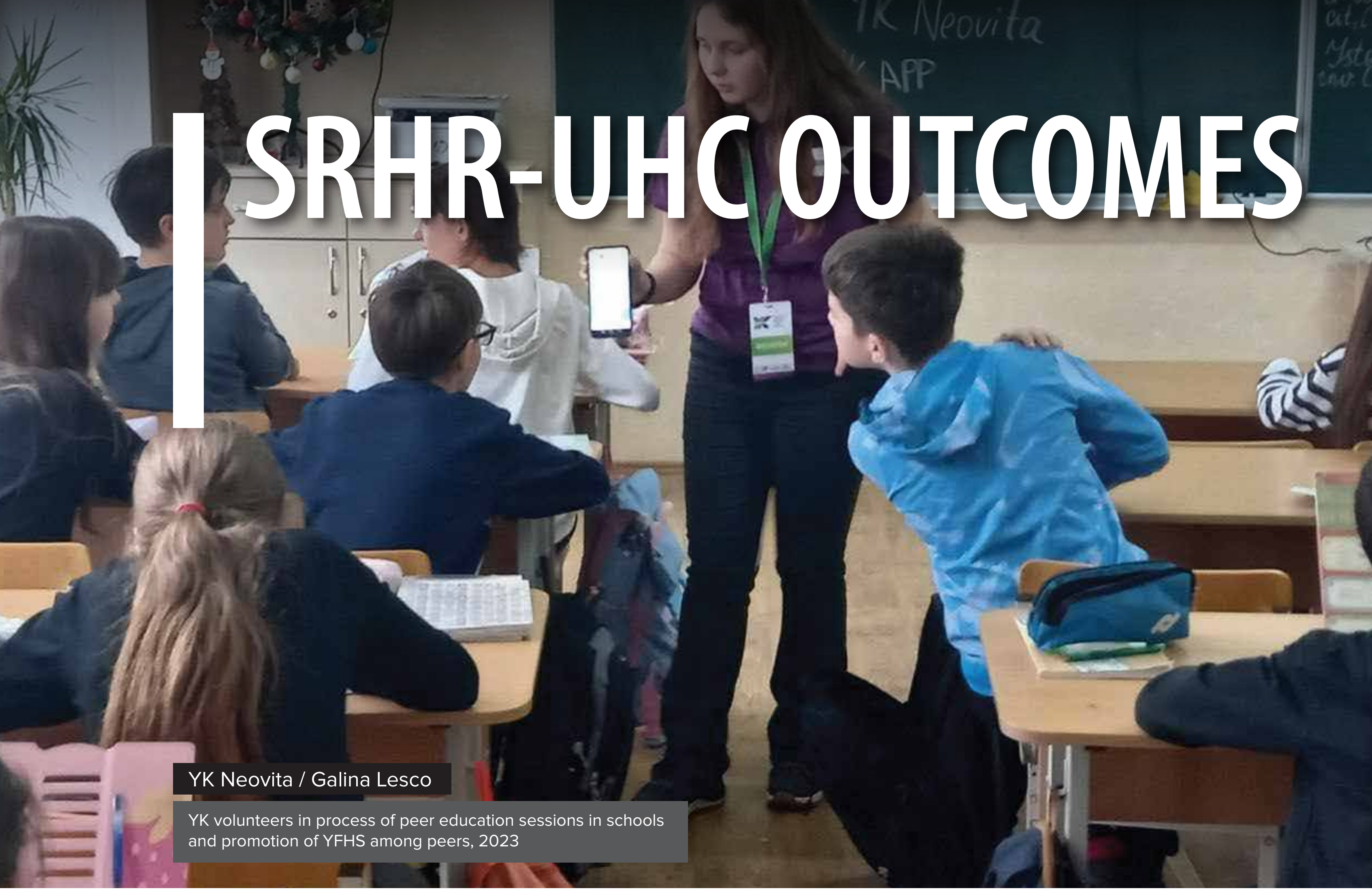
Health information systems: In addition to the national health management information system (HMIS), a separate confidential component – Youth Klinic-Informational System – was developed and implemented for YFHCs/YK to monitor activities of YFHS.

Medical products: Since 2017, contraceptive products and rapid tests for HIV, syphilis, hepatitis are procured by the State and distributed by family doctors, reproductive health o ces, YFHCs. It has been possible to procure medication for medical abortion for adolescents in one YFHC since 2012 and in all YFHCs since 2022–2023.

AUTHORS

Galina Lesco, Obstetrician-Gynaecologist, Head of Resourse Centre at the National Level în Youth Friendly Health Services NEOVITA, Moldova, galina.lesco@gmail.com
Joshua Amo Adjei, Cape Coast University, Ghana
Venkatraman Chandra-Mouli, Independent adolescent sexual and reproductive health and rights learner, communicator, advisor, teacher, and supporter of advocacy/research/action, Switzerland

SRHR-UHC OUTCOMES



YK Neovita / Galina Lesco

YK volunteers in process of peer education sessions in schools and promotion of YFHS among peers, 2023

SUCCESS

The strong legislative and policy environment, coupled with strengthening data and interventions aimed at increasing service delivery have led to improved ASRHR outcomes in the last decade. Access to YFHS for 10–24 year olds increased from 5% in 2011 to 38% in 2023. Outreach efforts resulted in a higher number of vulnerable service users and male beneficiaries accessing the services.

Contraceptive pill use among sexually active adolescents increased from 6% in 2014 to 13% in 2022, and the majority of sexually active adolescents (74%) continue to use condoms. The adolescent fertility rate declined from 34.2 per 1000 women aged 15–19 years in 2015 to 23 per 1000 women in 2022. At the same time points, abortion rates declined from 11.7 per 1000 women aged 15–19 years to 5.9/1000. HIV incidence among 15–24 years olds remained unchanged during the last decade and is more than two times lower than HIV incidence in the general population.

Challenges for YFHS include political, social and humanitarian instability, underfunding, limited access for young people from rural areas, and insuffcient mechanisms to motivate medical staff in hospitals and family doctors to apply the friendly approach to adolescents seeking medical care. Furthermore, the underdevelopment of school health services and lack of implementation of a complex health education program present obstacles to ensuring universal access to friendly health services for adolescents in the Republic of Moldova.

WHO & UNFPA: SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS AND UNIVERSAL HEALTH COVERAGE LEARNING BY SHARING PORTAL

Uganda

Implementing a quality improvement intervention for persons with disabilities in Uganda

Jhpiego Uganda / Josephine Achulet

Authors
- Sam Ongom, Jhpiego, Uganda, sam.ongom@jhpiego.org
- Thomson Ngabirano, Jhpiego, Uganda
- Josephine Nabukeera, Jhpiego, Uganda

60 Second Summary

Persons with disabilities (PWD) can face several barriers accessing sexual and reproductive health and rights (SRHR) services in Uganda. Jhpiego assessed the experiences of PWDs accessing SRHR services in 11 districts across two subregions of Uganda, finding reports of gender-based violence, stigma, negative attitudes of healthcare workers, physical inaccessibility, and communication challenges. The findings also revealed the family planning register does not have a column for disability. This baseline assessment helped implementation of the Advancing Sexual Reproductive Health and Rights in West Nile and Acholi Sub Regions in Uganda (ANSWER) project from July–December 2020. Activities included capacity building and training of trainers (TOT), mentoring of health workers on family planning, and training of district biostatisticians and health management information system focal persons as TOT who in turn mentored health workers in data management. Using service statistics at facility and district levels helps increase accountability of health workers.

World Health Organization

hrp

UNFPA

www.srhr.org/learn-uhc

In order to achieve UHC in general and SRHR within UHC in particular, we must analyze whether the services provided reach those furthest left behind. In this case, the focus was on PWD, and it was clear that with limited means—by making PWD visible in the data—access to quality SRHR services targeting PWD increased.

Dr. Mandira Paul

The Swedish International Development Cooperation Agency

IMPLEMENTING A QUALITY IMPROVEMENT INTERVENTION FOR PERSONS WITH DISABILITIES IN UGANDA

IMPLEMENTATION STORY

Uganda

60-SECOND SUMMARY

Persons with disabilities (PWD) can face several barriers accessing sexual and reproductive health and rights (SRHR) services in Uganda. Jhpiego assessed the experiences of PWDs accessing SRHR services in 11 districts across two subregions of Uganda, finding reports of gender-based violence, stigma, negative attitudes of healthcare workers, physical inaccessibility, and communication challenges. The findings also revealed the family planning register does not have a column for disability. This baseline assessment helped implementation of the Advancing Sexual Reproductive Health and Rights in West Nile and Acholi Sub Regions in Uganda (ANSWER) project from July–December 2020. Activities included capacity building and training of trainers (TOT), mentoring of health workers on family planning, training of district biostatisticians and health management information system focal persons as TOT who in turn mentored health workers in data management. Using service statistics at facility and district levels helps increase accountability of health workers.

SEXUAL AND REPRODUCTIVE HEALTH CHALLENGE

Delivering comprehensive sexual and reproductive health and rights (SRHR) interventions throughout the life course is an essential component of universal health coverage (UHC). Uganda's health sector development plan seeks to accelerate movement towards UHC, with a broad health infrastructure spanning all levels of national and local government administration, and a supporting monitoring and supervision framework. The national tracking system for health supplies holds regular sector reviews and has very strong private-public partnerships to support service delivery. Despite this, Uganda still has a long way to go to achieve UHC in critical health indicators. Approximately 72% of the Ugandan population live within 5 km of a health facility; only 13.4% of health facilities carry out scheduled maintenance of medical equipment; health workforce density is at 1.55 per 1000 population; 55% of health facilities are reporting availability of over 95% of a basket of commodities. Additionally, only 37.5% of hospitals offer intensive care services, health facility deliveries stand at 86%, and coverage of mandatory four antenatal visits is 37%.

UGANDA'S SRHR-UHC INTERVENTION

Societal discrimination remains a major barrier to the full inclusion of women with disabilities into society.

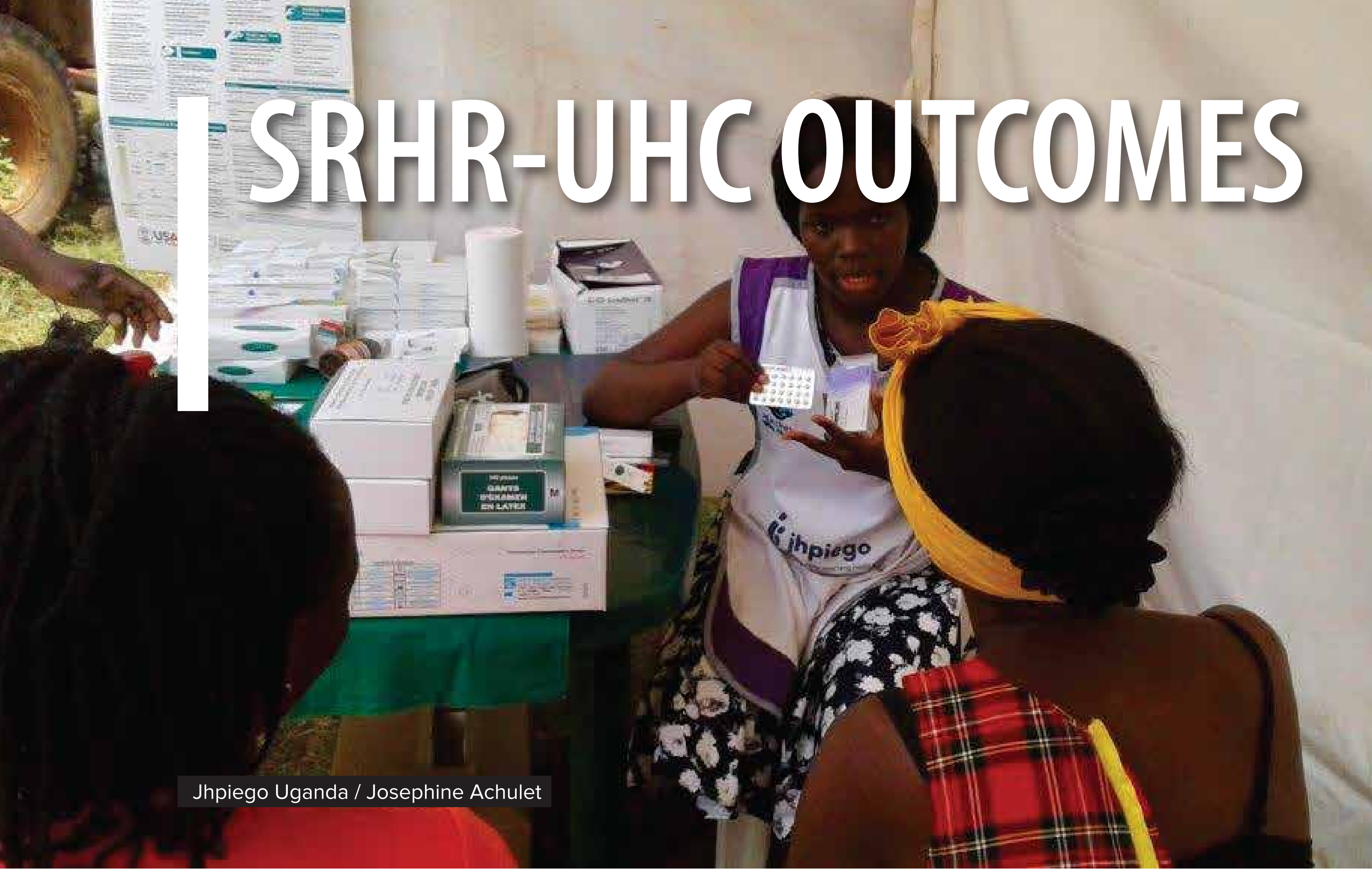
Jhpiego conducted a study to determine access to and utilization of SRHR services by persons with disabilities (PWD) in West Nile and Acholi subregions of Uganda under the 'Advancing Sexual Reproductive Health and Rights in West Nile and Acholi Sub Regions in Uganda (ANSWER)' project, funded by UNFPA. In October 2020, before the ANSWER project was implemented, an assessment was undertaken in eleven districts in the West Nile and Acholi subregions. The findings revealed the negative experiences that PWD encountered when accessing SRHR services (including HIV services), such as gender-based violence (GBV), negative attitudes of health care workers, stigma, physical inaccessibility, and communication challenges. Societal discrimination remains a major barrier to the full inclusion of women with disabilities into society.

The findings also revealed that the family planning register does not have a column for disability while the GBV register is kept blank even when GBV clients are being served. The baseline assessment aided in the implementation of the ANSWER project in 16 Ugandan districts (13 in West Nile and three in Acholi subregions) from July–December 2020. It began with start-up activities, including capacity building and training of trainers (TOT) for method mix (n=200, female=170, male=30), peer educators (n=615, female=266, male=349), mentoring of health workers on family planning (n=333, female=244, male=89]), training of 64 district biostatisticians and health management information system (HMIS) focal persons as TOT who in turn mentored 663 health workers in data management (filling the registers, compiling reports and entering into the DHIS2) according to the project reports.

AUTHORS

Sam Ongom, Jhpiego, Uganda, s_ongom@yahoo.com
Ngabirano Thomson, Jhpiego, Uganda
Nabukeera Josephine, Jhpiego, Uganda

SRHR-UHC OUTCOMES



Jhpiego Uganda / Josephine Achulet

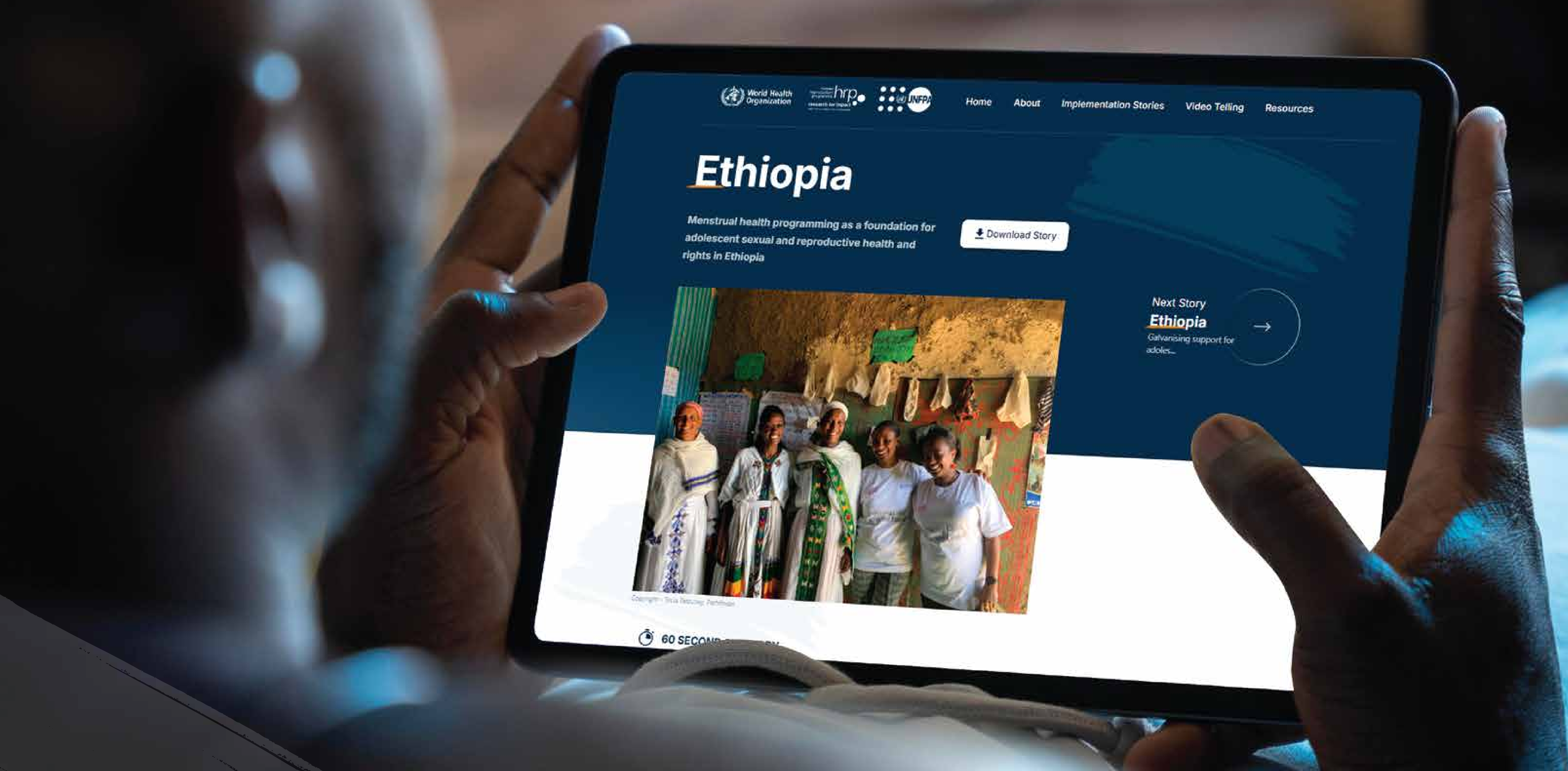
OUTCOMES

Discrimination by society, including health workers, was limiting PWDs' access to services. Following training of health workers under the ANSWER project, access improved. The project helped build the capacity of health care providers to serve PWDs and document this in all service registers. Data entry into the HMIS form 105 through to DHIS2 improved for family planning and GBV for PWDs. During implementation of the ANSWER project, 2665 PWDs received various SRHR services but data were not available in the DHIS2 for a similar period before the project began in 2019.

The six-month project encountered the following challenges during implementation; insufficient or lack of HMIS tools in districts and health facilities, including the registers of village health teams (VHTs), adolescent and youth friendly services, and sexual and gender-based health care, affected documentation of services provided. Also, there was a stockout of long-acting reversible contraceptives (for example, intrauterine devices and implants) at most of the health facilities.

View our Latest SRHR-UHC Implementation Stories

VISIT
www.srhr.org/learn-uhc



There is **NO UHC** without **SRHR**!

VISIT www.srhr.org/learn-uhc