

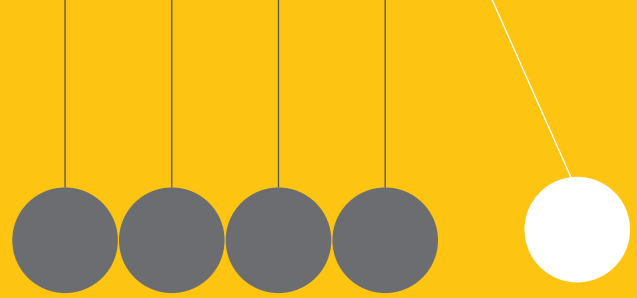


UNIVERSAL HEALTH COVERAGE

FOR SEXUAL AND REPRODUCTIVE HEALTH IN THE ASIA-PACIFIC REGION

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hera
right to health & development

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Disclaimer

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ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
AP	Asia-Pacific
ART	Antiretroviral Therapy
AFPPD	Asian Forum of Parliamentarians on Population and Development
CBHI	(Bangladesh) Community-based Health Insurance
CHD	(Mongolia) Centre for Health Development
CPA	(Cambodia) Complementary Package of Activities
CPR	Contraceptive Prevalence Rate
CSMBS	(Thailand) Civil Servants' Medical Benefit Scheme
DHS	Demographic and Health Survey
DS	Satisfied Demand for Family Planning
DSF	(Bangladesh) Demand-side Financing (voucher scheme)
EmONC	Emergency Obstetric and Neonatal Care
ESCAP	(UN) Economic and Social Commission for Asia and the Pacific
GBV	Gender-based Violence
HC	(Cambodia) Health Centre
Health BPJS	(Indonesia) (social security agency for health)
HEF	(Cambodia) Health Equity Fund
HMIS	Health Management Information System
HPV	Human Papillomavirus
IAEG	Inter-Agency and Expert Group
ICPD	International Conference on Population and Development
IDR	Indonesian rupiah
MDG	Millennium Development Goal
MHI	(Thailand) Migrant Health Insurance
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MOHFW	(Bangladesh) Ministry of Health and Family Welfare

MOLSP	(Mongolia) Ministry of Labour and Social Protection
MOPH	(Thailand) Ministry of Public Health
MPA	Minimum Package of Activities
MR	Menstrual Regulation
MRM	Medical Menstrual Regulation (Bangladesh)
NCCD	(Mongolia) National Centre for Communicable Diseases
NHSO	(Thailand) National Health Security Office
NIPORT	(Bangladesh) National Institute of Population Research and Training
NSO	(Mongolia, Thailand) National Statistical Office
OOP	Out-Of-Pocket (payment for health services)
OSCC	One-Stop Crisis Centre
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PNC	Postnatal Care
RH	(Cambodia) Referral Hospital
SBA	Skilled Attendance at Birth
SDG	Sustainable Development Goal
SHI	(Mongolia / Viet Nam) Social Health Insurance
SHPS	(Bangladesh) Social Health Protection Scheme
SRH	Sexual and Reproductive Health
SSK	(Bangladesh) (subsidised social health insurance)
SSS	(Thailand) Social Security Scheme
STI	Sexually Transmitted Infection
THE	Total Health Expenditure
UCS	(Thailand) Universal Coverage Scheme
UHC	Universal Health Coverage
UNGA	UN General Assembly
UNSTAT	UN Statistics Division

TABLE OF CONTENTS

Summary	2
Effective coverage of sexual and reproductive health services	2
Equitable access to sexual and reproductive health services	3
Financial risk protection for sexual and reproductive health services	3
Key issues	4
The UN Agenda for Sustainable Development	5
Sexual and reproductive health services in Asia-Pacific	6
The scope of the study of UHC for SRH	8
Bangladesh	9
Cambodia	13
Indonesia	17
Mongolia	21
Thailand	25
Viet Nam	29
Universal health coverage for sexual and reproductive health	33
Effective coverage of SRH services	34
Equitable access to SRH services	43
Financial risk protection for sexual and reproductive health services	47
Conclusions and recommendations	53
References	59

SUMMARY

The study reviewed the progress in six countries of the Asia-Pacific region towards the achievement of the UN Sustainable Development Goals 3.7 and 3.8.

SDG Goal 3.7: By 2030, ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

SDG Goal 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

Progress towards the achievement of universal access to sexual and reproductive healthcare (SRH) was assessed according to a framework proposed in 2010 that lists 11 key services for comprehensive SRH. Some services, for instance infertility treatment, were not included in the assessment after consultation with the UNFPA Regional Office.

Bangladesh, Cambodia, Indonesia, Mongolia, Thailand and Viet Nam have made national policy commitments to achieve universal health coverage, each starting from a different baseline of health service development and health financing, but each working towards a system of a unified mechanism to pool resources for a health financing system that would protect households from high levels of payment for healthcare at the point of service.

Initiatives started in Mongolia in 1994 with the introduction of a mandatory social health insurance, followed by Thailand in 2002, Indonesia in 2004, Viet Nam in 2008, Cambodia in 2011 and Bangladesh in 2012. By 2015, the six countries had achieved different levels of service coverage and financial risk protection. Thailand had reached a high level of coverage for sexual and reproductive health services with low point-of-service charges to clients, while Bangladesh was among the Asia-Pacific countries with the lowest service coverage levels and the highest direct user charges.

EFFECTIVE COVERAGE OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The Asia-Pacific region achieved significant progress in increasing the coverage of effective sexual and reproductive health services. The maternal mortality ratio declined by two thirds between 1990 and 2015, the contraceptive prevalence rate at 87.4 percent was three percent above the global level in 2015, and the adolescent birth rate of 35/1,000 was considerably lower than the global average of 52/1,000. The coverage of antiretroviral therapy for HIV was however five percent below the estimated global average of 46 percent. While the HIV prevalence in the region is low, the incidence of other sexually transmitted infections is higher than the global average.

These regional statistics, however, hide many details. Some countries in the region still record very high maternal mortality ratios, low contraceptive prevalence rates, and very high adolescent fertility. Only a small proportion of sexually active adolescent girls in Asia-Pacific are unmarried, but access to effective female-controlled methods of contraception for these girls is particularly low. Furthermore, in four of the six study countries, adolescent birth rates in 2014 were higher than the levels recorded in 2005. Among the six study countries, the coverage of HIV antiretroviral treatment ranged from nine percent in Indonesia to 74 percent in Cambodia.

Access to safe termination of pregnancy and post-abortion care varies among the countries, depending on the national abortion laws. However even countries with relatively unrestricted access to pregnancy termination still register large numbers of unsafe abortions, especially among adolescents. Only Bhutan, Malaysia and several Pacific Island States have introduced HPV immunisation in their national immunisation programmes, while in the other countries this service is still in a pilot phase.

National screening programmes for cervical cancer exist in all six study countries, but only Thailand records a significant coverage at 60 percent. Several countries in the region have established comprehensive one-stop crisis centres for girls and women who are survivors of gender-based violence. The centres are integrated in the national health systems in four countries of the region, in others they exist as pilots or in an early scale-up phase.

EQUITABLE ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The social equality gap in the use of family planning and maternal health services has narrowed over time. In the six study countries, there are no inequalities in the use of modern contraceptives among married women, but the gap in adolescent fertility has not narrowed. Regionally, the difference in the adolescent birth rate between women in the lowest and the highest wealth groups increased between 1998 and 2008. For skilled attendance at birth, the gap between high and low-income groups narrowed in Indonesia and Cambodia, but it increased in Bangladesh. Women resident in rural areas, remote regions and some island provinces have lower access and utilisation rates for reproductive health services, often because of irregular supplies and stock-outs of contraceptive commodities. Ethnic minority groups and the large population of international migrants in Asia-Pacific (estimated at 27.6 million) face numerous barriers of access to health services, but information about utilisation rates and reproductive health outcomes among these groups is limited.

FINANCIAL RISK PROTECTION FOR SEXUAL AND REPRODUCTIVE HEALTH SERVICES

A mix of different financial protection schemes exist in the six study countries. Efforts to consolidate them into a single national social health insurance scheme are furthest developed in Mongolia and Viet Nam, and relatively far advanced in Indonesia. In Thailand, however, three parallel health insurance schemes continue to coexist and achieve the highest levels of insurance benefit and population coverage among the six study countries.

Some sexual and reproductive health services in the other five countries are not included among the health insurance benefits, but are provided in public health facilities with varying levels of user-charge exemptions.

Bangladesh has a fragmented system with a demand-side financing (voucher) scheme for maternal health services in 53 sub-districts and public health provision of family planning services throughout the country. In Cambodia, financial risk protection is primarily provided through user-fee subsidies in public health facilities for poor people, and through health equity funds that reimburse the cost of healthcare for the poor. Both countries are in the early stages of developing a national social health insurance.

With the exception of Thailand, and more recently Indonesia, social health insurance schemes do not provide benefits for family planning services. They are provided free of charge to targeted populations through public health services; in Viet Nam, for instance, to ethnic minority populations; in Mongolia and Cambodia to poor and vulnerable groups. Population surveys in Bangladesh document that many women bypass free public family planning services in favour of buying services in the private sector. In all study countries except Thailand, there is a tendency to focus social health insurance benefits on medical treatment and hospital services, while prevention services, including for sexually transmitted infections, are provided by public health systems with varying service coverage and varying levels of user-charge exemptions.

Services that require multi-sector interventions, for instance services for the prevention and response to gender-based violence, are generally not covered by social health insurance. Migrant populations are excluded from national financial risk protection schemes in most countries. Only Thailand operates a health insurance schemes for unregistered migrant workers, which however only covers about 40 percent of the estimated target population of 3.4 million.

KEY ISSUES

- Without questioning the potential of the global UHC goals to contribute to better services and improved health for all, there is a risk that the UHC goals will focus decision-makers at national level, as well as international development partners, on improving treatment services at the expense of prevention and health promotion. The exclusion of family planning services from many national UHC schemes is a concern, especially as they affect the sexual and reproductive health and rights of adolescent girls.
- Improving sexual and reproductive health requires changes in social norms to protect the rights of girls, promote gender equality, and improve the access to information on health and rights among adolescents. Preventing and responding to gender-based violence requires the participation of many sectors, including education, justice, social affairs and health. Such multi-sector responses cannot be wrapped up under a single UHC agenda.
- A history of international, national and local initiatives has left traces of different types of health financing arrangements in most countries. Consolidating several initiatives under a single UHC umbrella can create efficiencies that allow an expansion of coverage and level of financial protection. Consolidations that are relatively less selective of the type of beneficiaries are less likely to make errors of omission, without necessarily generating revenue losses from foregone insurance premiums. Consolidation should, however, be approached with caution to assure that no essential SRH service nor any vulnerable population group lose their coverage. By including prevention and health promotion among the UHC benefits, future costs for treatment can be reduced and the sustainability of the UHC schemes consolidated.
- Sexual and reproductive health service coverage for adolescents is lagging behind the general trend of improved service coverage in the region. Insufficient financial risk protection may not be the most important reason. In the development of financial risk protection schemes, however, the special situation of adolescents should be kept in mind. Adolescents do not necessarily have ready access to the financial resources of the economic group in which they are categorised.
- Although there are examples of SRH programmes and financial risk protection schemes that target vulnerable groups such as ethnic minority populations, migrant workers or refugees, they are the exception rather than the rule. There are major service coverage gaps that are reflected in health statistics. Meeting national targets for sexual and reproductive health will require that equity gaps be narrowed, including the gaps that separate migrants from citizens and ethnic minorities from the majority.
- Assessments of progress towards UHC in sexual and reproductive health that can generate actionable information for national decision-makers are constrained by important information gaps. They include information about service quality and about reasons why clients do not always take advantage of public services provided free of charge; information about the cost-drivers for out-of-pocket expenditures; information about coverage of migrant populations; and information about the households among whom out-of-pocket expenditures for health constitute a serious financial risk.

THE UN AGENDA FOR SUSTAINABLE DEVELOPMENT

On September 25th 2015, the UN General Assembly adopted the Agenda for Sustainable Development entitled '*Transforming our World*'. [1] It includes 17 Sustainable Development Goals (SDGs) to be achieved by 2030. The third goal is focused on health and well-being and includes two sub-goals:

- 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all



An Inter-Agency Expert Group (IAEG) developed the monitoring framework for the SDGs. It presented its final list of 232 indicators in March 2017, including two indicators each for SDG 3.7 and SDG 3.8. [2]

- 3.7.1 Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
- 3.7.2 Adolescent birth rate (aged 10-14 years; aged 15-19 years) per 1,000 women in that age group
- 3.8.1 Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)
- 3.8.2 Proportion of population with large household expenditures on health as a share of total household expenditure or income

The two SDG goals are closely linked. Sexual and reproductive health (SRH) services are essential services and therefore also included under universal health coverage (UHC). The components of a comprehensive package of essential SRH services were proposed in 2010:[3]

- Family planning and birth spacing services
- Antenatal care, skilled attendance at delivery, and postnatal care
- Management of obstetric and neonatal complications and emergencies
- Prevention of abortion and management of complications resulting from unsafe abortion
- Prevention and treatment of reproductive tract infections and sexually transmitted infections including HIV
- Early diagnosis and treatment for breast and cervical cancer
- Promotion, education and support for exclusive breast feeding
- Prevention and appropriate treatment of sub-fertility and infertility
- Active discouragement of harmful practice such as female genital cutting
- Adolescent sexual and reproductive health
- Prevention and management of gender-based violence

The priority SRH needs differ among populations, and the list of essential SRH services must therefore be adapted to the country context. Furthermore, some of the services in the list are highly aggregated, for instance 'adolescent sexual and reproductive health'. When conceptualised within a rights-based framework, the package of activities to promote and protect the sexual and reproductive health of adolescents expands into many components that extend well beyond services in the health sector.

The UHC indicator 3.8.1 for monitoring service coverage is based on 16 tracer health services, including three SRH services, namely family planning, antenatal and delivery care, and cervical cancer screening. But with a total of 126 sub-goals in the SDG agenda, global indicators to monitor any one goal have to be highly aggregated. At the country and regional level, there is a need for disaggregation, to understand the extent to which commitments to achieve universal health coverage of essential sexual and reproductive health services are met, including those that are not captured by the global monitoring system.

SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN ASIA-PACIFIC

The UNFPA Asia-Pacific (AP) region comprises 37 nation states, including 14 Pacific Island countries. With a total population of about four billion, it is home to more than half of the world's population. The region includes countries that rank in the low, medium and high range of the UNDP human development index table. Averaging indicators to establish a regional profile would therefore not be very informative.

THE UNFPA ASIA-PACIFIC REGION



- Afghanistan
- Bangladesh
- Bhutan
- Cambodia
- China
- Cook Islands
- D.P.R. Korea
- Federated States of Micronesia
- Fiji
- India
- Indonesia
- Iran
- Japan
- Kiribati
- Lao P.D.R
- Malaysia
- Maldives
- Marshall Islands
- Mongolia
- Myanmar
- Nauru
- Nepal
- Niue
- Pakistan
- Palau
- Papua New Guinea
- Philippines
- Samoa
- Solomon Islands
- Sri Lanka
- Thailand
- Timor-Leste
- Tokelau Islands
- Tonga
- Tuvalu
- Vanuatu
- Viet Nam

Many countries in the Asia-Pacific region are experiencing large international population movements. The 2015 Asia-Pacific Migration Report estimated that more than 18 million migrants lived in five countries that are among the ten top destination countries for international migration in the region (India, Pakistan, Thailand, Iran and Malaysia). [5] A large proportion of the migrants are young people whose needs for health care are mostly for sexual and reproductive health. The extent to which they have access to SRH services and to financial protection at the same level as the national population is a key equity dimension in the universal health coverage profile of each country.

A general overview of the situation of universal health coverage of sexual and reproductive health services can be presented in a scatter diagram, plotting an index of SRH coverage on the vertical axis and a financial risk protection index on the horizontal axis. The SRH service coverage index is calculated from three indicators that are included among the global indicators for monitoring the SDGs:

- Adolescent birth rate per 1,000 women aged 15 to 19
- Proportion of family planning demand satisfied with modern methods (women aged 15 to 49)
- Proportion of births attended by skilled health personnel

The financial risk protection index should ideally reflect the SDG indicator of 'proportion of population with large household expenditures on health as a share of total household expenditure or income'. Data for this indicator, however, are not widely available. Instead, the proportion of total health expenditure that is paid by patients and clients out of pocket is used. This is not an ideal indicator, because cash-for-service requirements differ by type of service. They may be particularly high for some SRH services that are excluded from health insurance coverage, including family planning. The indicator also does not reflect uneven coverage for adolescents, migrants and minority groups who may be uninsured to a much higher degree than the rest of the population.

OVERVIEW OF SRH SERVICE COVERAGE AND FINANCIAL PROTECTION IN ASIA-PACIFIC¹



Data sources: Ref [6], [7]

An overview as presented in this graphic is useful for orientation. It shows that the countries in the region map out across a broad range, some with low SRH service coverage and minimal financial protection and some with high coverage and a high level of financial protection. Details, however, are lost. Sexual and reproductive health services range from sexuality education for adolescents to the treatment of cancers of the reproductive system. The scope is wide, and not all services are provided in the health sector. Financial risk protection can also take different forms, including direct public financing of health services; third party payment for services by a social insurance scheme that may be financed from general tax revenues, insurance premiums, or a combination of both; a variety of financial risk pooling arrangements including private health insurance or community mutual funds; and cash transfer or voucher schemes, typically to offset indirect costs of seeking health care. A detailed review that covers the range of services, the financial risk reduction schemes, and the equity of access can only be done at the level of each country.

¹ DPR Korea and 9 Pacific Island Countries are not included because of incomplete data

THE SCOPE OF THE STUDY OF UHC FOR SRH

For the study, six countries with documented commitments to UHC were selected as a focus:

Bangladesh	adopted a health financing strategy in 2012 with a roadmap to achieve universal health coverage by 2032. [8]
Cambodia	adopted the 'National Social Protection Strategy for the Poor and Vulnerable' in 2011 followed by the 'National Social Protection Policy Framework 2016-2025'. The long-term vision presented in these documents is a comprehensive system of universal health coverage. [9], [10]
Indonesia	initiated a national social security reform in 2004, with national health insurance as the first of five social security programmes to be introduced. [11] The national health insurance programme was launched in 2014.
Mongolia	introduced mandatory social health insurance in 1994, and in 2013 adopted a long-term strategy for the development of social health insurance (2013-2022).[12]
Thailand	committed in the National Health Security Act of 2002 to establish a National Health Security Fund 'to encourage access by persons to universal and efficient health service'. [13]
Viet Nam	introduced a health insurance law in 2008 and revised it in 2014 with a target to reach universal health coverage by 2020. [14], [15]

The six countries are low or middle-income countries with a combined population of about 600 million, which is almost half of the population of the Asia-Pacific region excluding China and India.

The scope of sexual and reproductive health services reviewed in the study is wide but not fully comprehensive. Some essential SRH services are not included, for instance treatment of breast cancer, infertility treatment, support for exclusive breast feeding, and health services for the prevention, diagnosis and treatment of sexually transmitted infections (STI) among populations other than adolescents and pregnant women. This leaves out STI and HIV services for men, transgender and intersex persons.

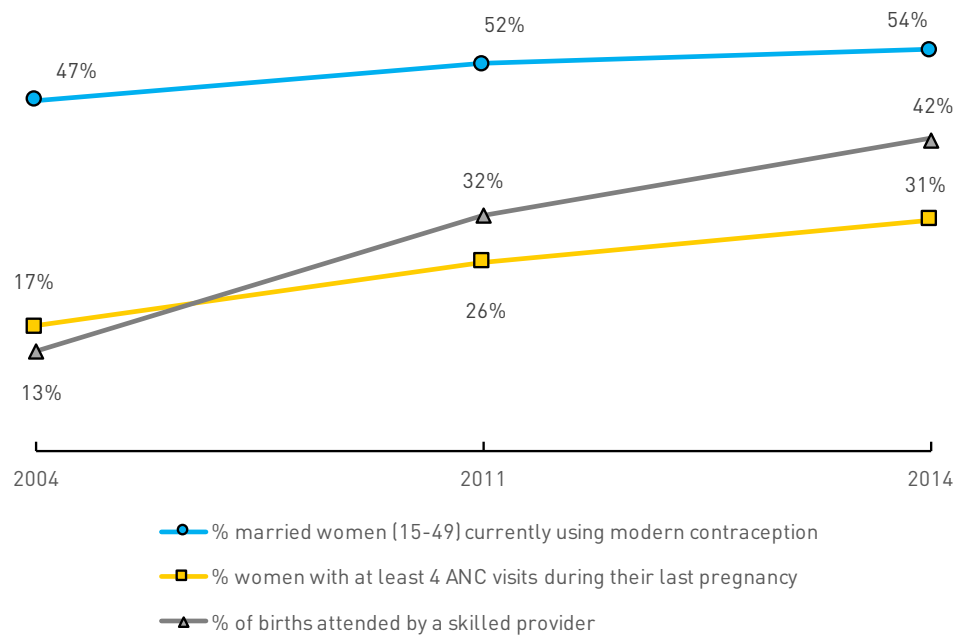
Four countries, Indonesia, Mongolia, Thailand and Viet Nam introduced national health insurance schemes, aiming to achieve a single third-party payment system for all essential health services. For these countries, the study aimed at documenting the sexual and reproductive health services that are covered by the insurance, as well as the inclusiveness and equity of coverage. In Bangladesh and Cambodia, efforts to establish a national social health insurance are still at an early stage, and the purchasing arrangements for health services are more fragmented. Several public and private schemes coexist, together with a public health system that provides certain services free of charge to users. In these countries, the study aimed at documenting the different types of schemes and their interactions, including only those that aim at national coverage and that have a clear objective to protect users from social hardship. Data were collected in November and December 2016 through document reviews and interviews with key informants in the six countries.

BANGLADESH



BANGLADESH

TRENDS OF SELECTED SRH INDICATORS



Sources: [16], [17], [18]

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Health services in the public sector in Bangladesh are delivered by the Ministry of Health and Family Welfare (MOHFW) through a network of health centres and hospitals from the primary to the tertiary level. The private health sector is large and has been growing at approximately 15 percent per year since 2000. In 2013, approximately half of registered clinic and hospital beds in the country were in the private sector, and 62 percent of medical doctors were engaged in private practice. [19] Private for-profit health facilities are concentrated in the urban areas. In addition, a large number of health facilities for primary and secondary care are operated by NGOs and confessional organisations, primarily in rural and in high density urban areas.

Although public facilities provide health services without charge to clients or at subsidised user fees, the proportion of health expenditures covered by out-of-pocket payments has continued to increase. At 67 percent, it is one of the highest in the region. Two reasons are cited to explain this trend. Limitations of service quality and availability in the public sector motivates clients to seek care in the private sector and accept to pay for services that are perceived to be of better quality. At the same time, the service offer of public facilities has contracted because of financial shortages. Medicines and services that were previously provided free of charge are now often only available at private pharmacies or laboratories. [19]

Contraception: The uptake of family planning was one of the early successes of population programmes in Bangladesh. Between 1975 and 2014, the total fertility decreased from 6.3 to 2.3 births per woman. In 2014, about 73 percent of the demand for modern family planning was satisfied, with small differences between geographic or socially stratified groups. The adolescent fertility rate, however, did not follow the trend. After a sharp increase in the 1980s it decreased slowly, but in 2014 it was still at the high level of 113 births per 1,000, about the same level as in 1975. The main reason is the early age of marriage among girls in Bangladesh. In 2014, more than half (59%) of young women were married before the age of 18, with even higher proportions in rural areas. [18]

Menstrual regulation by vacuum extraction of uterine content to re-establish menstrual flow in case of a delayed menstrual period has been part of the Bangladesh national family planning programme since 1979. Menstrual regulation is available free

of charge in public clinics which provide about two thirds of these services. Medical menstrual regulation through the induction of uterine bleeding by pharmaceutical means was added more recently in some facilities.

Termination of pregnancy is illegal in Bangladesh under the 1860 Penal Code unless performed to save a woman's life. Despite the wide availability of contraceptive services, including menstrual regulation, the use of induced unsafe abortions is prevalent. The estimated rate of complications following induced abortions (6.5/1,000) is comparable to other countries with restrictive abortion laws. [20] Post abortion care is available in most public and private hospitals.

Maternal health services, including antenatal, obstetric and postnatal care, are provided in public and private health facilities. A maternal health voucher system has stimulated uptake of services. The vouchers can be redeemed in public and in accredited private facilities.

The use of antenatal care has increased, but in 2014 it was still low, with only 31 percent of women reporting that they had attended four or more antenatal consultations during their last pregnancy. All increases in antenatal care between 2011 and 2014 were due to an increasing use of the private sector which accounted for 52 percent of antenatal consultations in 2014. [18] HIV screening, syphilis screening and malaria prevention are not routinely provided as part of antenatal care.

Deliveries in health facilities increased from 12 percent in 2004 to 37 percent in 2014. The majority of deliveries, however, still take place in the home. Private hospitals and maternity homes have become by far the most favoured places of delivery, with almost twice as many births as in public sector facilities. There have been major investments under the 2011-2016 health strategy to achieve national coverage of basic and comprehensive emergency obstetric and neonatal care services, however not all established centres are able to provide the full range of service, and coverage in several provinces is still below the recommended minimum density.

The national incidence of delivery by caesarean section of 23 percent of births is very high. Among women in the higher socio-economic strata, caesarean sections account for half of all deliveries. A study among 500,000 women who gave birth between 2005 and 2011 found that 73 percent of deliveries in the private sector were by caesarean section, suggesting that the private sector is driving a high caesarean section rate that is not always medically indicated. [21]

Diagnosis and treatment of **sexually transmitted infections** are provided in public facilities and NGO clinics. Statistics about the prevalence of sexually transmitted infections in key populations such as sex workers and truck drivers are available, but there is little information about the prevalence of STIs in the general population. Reports of syphilis screening among pregnant women are scarce. The only available data come from three tertiary hospitals where one third of the antenatal clients were tested for syphilis. Among 626 women, two were found to be infected and one received treatment. [22]

The prevalence of **HIV infection** is low in Bangladesh. Among people who inject drugs, female sex workers, and men who have sex with men the prevalence is estimated at 0.7 percent. HIV programmes primarily focus on prevention among these groups. Almost all services for HIV, including antenatal testing and PMTCT, are provided by programmes that rely on international funding. They are not covered by the public health service. [23] PMTCT services are available in three government tertiary care hospitals and in a few private facilities. The number of women tested is small, only 13 percent of those who tested positive received anti-retroviral treatment (ART) during delivery, and only 1.4 percent during breastfeeding. [22]

Immunisation against **Human Papillomavirus** (HPV) is currently being piloted in one district, aiming to immunise about 33,000 adolescent girls. The cervical cancer burden in Bangladesh is estimated at 29.8 per 100,000 women per year. Cancers are usually diagnosed in advanced stages as access to screening and early treatment is limited. [24]

Services for the treatment and support of women survivors of sexual violence are provided by the Ministry of Social Welfare.

FINANCIAL RISK PROTECTION

Public health services are nominally free or provided at subsidised rates. The high level of out-of-pocket expenditures for health indicates that the public health service model is not working as intended. A survey in an urban area of Bangladesh in 2013 reported that between 10 and 18 percent of households experienced an incidence of catastrophic health costs within the three-month study period. [25] Two public financial risk protection schemes are meant to reverse the trend of increasing out-of-pocket expenditures. In addition, there are a large number of community-based or micro insurance schemes.

Shasthya Shurokkha Kormoshu (SSK) (subsidised social health insurance) is the first and only social health insurance scheme under the MOHFW. It is fully financed from general government revenues. The long-term vision for SSK is of a scheme combining risk pooling with a purchaser-provider split under the stewardship of the MOHFW. In a first phase, only the poor are covered, and the government pays their insurance premiums. In the long run, other groups will be included as paying members. A three-year pilot SSK scheme opened in March 2016, targeting a population of about 95,000. It is expected to increase access to hospitals and improve the quality of services by generating income for the facilities which they can use for improvements. [26]

The SSK benefits include inpatient care for fifty specified health conditions in selected public facilities. They do not include contraceptive and menstrual regulation services; HIV testing and treatment; cervical cancer prevention, detection and treatment; and services for survivors of gender-based violence, child abuse or rape. The main challenges faced during the pilot phase of SSK include coping with the increased demand for services while developing reliable procedures to manage an efficient third-party payment system for providers.

The **Maternal Health Voucher / Demand Side Financing scheme (DSF)** started in 2007 as a pilot programme of the MOHFW in 21 sub-districts. It was scaled up in 2010 to cover 53 sub-districts in 41 districts and a target population of about 26.5 million. At inception, the beneficiaries of the DSF scheme were pregnant women during their first or second pregnancy who were considered poor after a formal means test. In nine sub-districts, 'universal intervention' was piloted, extending the DSF benefits to all women. Vouchers provide a range of benefits, including comprehensive coverage of antenatal, delivery and postnatal care, transport subsidies and cash incentives for mothers who deliver with the attendance of a skilled provider. Public, NGO and private sector health facilities that are accredited are reimbursed at a fixed rate for the vouchers they collect. The total cost of the programme per voucher distributed was estimated at US\$ 41 in 2010. [27] The programme is primarily financed by international development partners. Technical assistance is provided by WHO. Evaluations of the programme in 2011 and 2014 found that the scheme increased the demand for reproductive health care among poor women, and that it reduced the average out-of-pocket costs for normal deliveries from US\$ 25 to US\$ 21 and for caesarean sections from US\$ 103 to US\$ 65. [28],[29]

Community-based and micro health insurance schemes are managed by NGOs. The schemes are funded with insurance premiums, cross-subsidisation from other NGO programmes, and international and national donations. The schemes target poor and disadvantaged groups as well as members of the micro-credit groups operated by the same NGO. Benefits differ among the micro-insurance schemes. Most of them cover basic and preventive health services including immunisation, family planning, out-patient consultations, and normal deliveries. [30]

UNIVERSAL COVERAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Bangladesh is in the early stages of moving from a public health service model under which health care is provided by government and free of charge to users, to a social insurance model under which health services in the public and private sector are purchased by a health insurance provider who is funded with insurance premiums and general government revenues.

Out-of-pocket payments for health care have continued to increase and there has been a continued drift of patients to the private sector. This gave rise to the emergence of multiple community and micro-insurance schemes that provide a limited amount of financial protection to some. The voucher scheme for maternity care is a more ambitious initiative, documenting that the equity and coverage of health services can be increased by offering payments for services to providers, while protecting users from expenditures. A large proportion of the increased coverage was achieved by the private sector, indicating the limitations in service capacity and quality of the public health sector. The high caesarean section rates among private sector deliveries, however, suggest that the scheme generates incentives for performing caesarean sections without medical indication.

Beyond maternity care, the coverage of SRH services, for instance for HPV immunisation, cervical cancer screening, or syphilis and HIV testing in pregnancy, is limited. For services that are available and provided free of charge in the public sector, for instance for family planning and menstrual regulation, an increasing number of women consult private sector providers and pay for the service. This suggests that these services also face issues about declining availability and acceptance, despite the substantial public delivery infrastructure that was established.

The long-term goal pursued in Bangladesh is national coverage of the entire population with the SSK social health insurance scheme. SRH services, other than maternity care, are, however, not included in the benefit package of SSK as it is currently being piloted. While these services will for now still be offered through special projects or by the public health service, the offer is limited and the drift to the private sector will likely continue. This means that user charges for SRH services will not disappear and may even rise, as more and more of these services are pushed into the private sector.

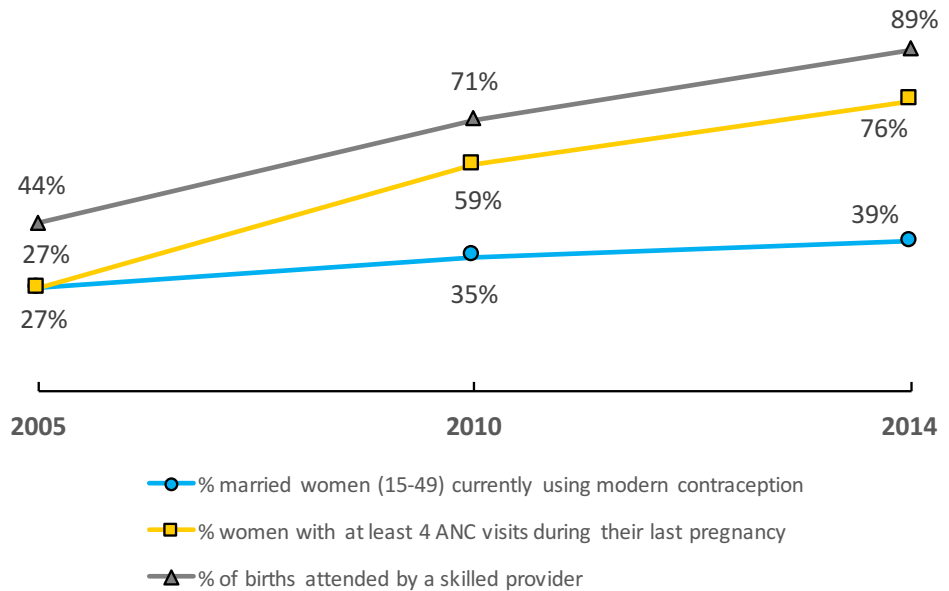
Because the systems for financial risk protection in Bangladesh are fragmented, the equity of coverage is difficult to determine. The SSK scheme protects the poor, but only as a pilot programme with small coverage. The voucher scheme also has a pro-poor focus, but it covers only about 20 percent of the population. Public health services theoretically offer universal financial protection, but they are bypassed by more and more people at all levels of the socio-economic scale, with the result that they do not deliver equitable protection from catastrophic health expenditures.

CAMBODIA



CAMBODIA

TRENDS OF SELECTED SRH INDICATORS



Sources: [31],[32],[33]

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Health services in Cambodia are provided in the public and private sector, including by a variety of NGO-operated not-for-profit health facilities. Two packages of services have been defined for public sector facilities, the Minimum Package of Activities (MPA) provided primarily at the health centre level and the Complementary Package of Activities (CPA) which is available in hospitals. [34]

Contraception, including family planning counselling, provision of implants, IUDs, pills, condoms, male and female sterilisation, are included in the MPA and CPA. Utilisation and availability of modern contraception is slowly increasing. The most widely used methods are contraceptive pills. The uptake of long-acting contraceptive methods remains limited, but availability in public health facilities is increasing annually. Emergency contraception was introduced in the public sector in 2012 and is reported to be available, although there is little information about access and use. [35],[36] The total fertility rate in Cambodia declined from 3.4 births per woman in 2005 to 2.7 in 2014. The adolescent fertility rate at 57 births per 1,000 women aged 15 to 19 is comparable to other countries in South-East Asia, but shows an increasing trend over the past years. [33]

Termination of pregnancy in the first trimester was legalised in Cambodia in 1997. Between 2005 and 2015 the proportion of women who had at least one abortion within the past five years doubled from 3.5 to 6.9 percent, however deaths related to unsafe abortions decreased dramatically. In 2005, at least one death was reported by 10 percent of hospitals, falling to one percent in 2009. [37] Most terminations (44%) are performed in private health facilities and about 61 percent under the care of a qualified provider. Vacuum aspiration is the most common method followed by medical termination. The public sector has a secondary role in the provision of abortion services. [33],[38]

Maternal health services are provided under MPA and CPA. Public sector facilities dominate in the provision of maternity services with little difference in use according to social group or residence. Antenatal care consultations, including tetanus immunisation, provision of folic acid and iron and micro-nutrient supplementation are available at health centre level through MPA, but laboratory analyses and ultrasound examinations are only available at referral hospitals. Normal deliveries and post-natal care consultations are also conducted at health centres, whereas assisted deliveries, caesarean sections and blood transfusion are only performed in hospitals. Treatment for fistula and other in-patient hospital services are available at the referral hospital, covered by the CPA. In 2014, 76 percent of Cambodian women attended four or more ANC consultations and 89 percent of births were attended by a skilled health care provider. [33]

Prevention and treatment of malaria during pregnancy is included among the antenatal services, however the coverage is low. A recent study estimated that 21 percent of the population is at risk of malaria in 20 out of 24 provinces. However, malaria tests are not routinely conducted during ANC visits as malaria is often not suspected. Laboratory services are still not strong enough to ensure diagnosis by quality assured microscopy or rapid diagnostic tests. [39]

Services for **sexually transmitted infections** are available for pregnant women and adolescents at health centre level, including HIV testing, counselling, and prevention of HIV transmission from mother to child. Laboratory analysis of STIs as well as provision of ARVs are only available at referral hospitals. There are counselling and testing sites in almost every referral hospital. They are not integrated into general outpatient services, but they are provided as integral part of antenatal care. [36]

Immunisation against **Human Papillomavirus** and comprehensive services for cervical cancer prevention, detection and treatment should be available at the referral hospitals through the CPA, however, the availability of these services remains severely limited. There are currently pilot projects for screening and treating cervical cancer in the provinces but treatment remains concentrated at the district hospital level. The availability of treatment options for those already diagnosed with cervical cancer remains limited. Cambodia's first national cancer centre is expected to be operational by 2017. [34]

Currently, services available for **survivors of gender-based violence** are limited to HIV post-exposure prophylaxis, emergency contraception and STI screening and treatment. Following the adoption of the national guidelines for the management of violence against women and children in 2014, the Ministry of Health is undertaking efforts to build capacity, improve access to forensic services, strengthen referral systems, and reduce delays in providing care to women who experienced violence. [40]

FINANCIAL RISK PROTECTION

Per person out-of-pocket expenditures for health in Cambodia are high. They increased three-fold between 2000 and 2014 from US\$ 14 to US\$ 45, while they fluctuated as a proportion of total health expenditures between 60 and 80 percent. [6]

In 2016, Cambodia adopted the 'National Social Protection Policy Framework 2016-2025' with the two main pillars of social assistance and social insurance. [10] It is expected to eventually replace a fragmented system of health financing and financial risk protection that includes government subsidised and user-fee financed services provided in public and contracted NGO health facilities, community-based health insurance, health equity funds, and voucher schemes. [41]

- Public sector health facilities provide services defined in the CPA and MPA packages at fixed user fees with exemptions for the poor. The service packages include all medical services for sexual and reproductive health, but the use of public facilities for these services is variable, ranging from 16 percent for termination of pregnancy to 76 percent for female sterilisation. [33]
- Health Equity Funds cover approximately 18 percent of the population. They are financed from a pool of shared government and development partner contributions. Beneficiaries are identified according to their household economic situation through a formal participatory mechanism. The benefits include partial or full reimbursement of expenditures for services included in the MPA and CPA packages, food, transport and funerals.
- Several community-based health insurance schemes provide similar benefits as the health equity funds, but target primarily informal sector workers above the national poverty line. The coverage is less than one percent of the population.
- Voucher schemes for reproductive health services for poor women are operated by a number of NGOs, but coverage is also very low.
- Social health insurance was recently introduced to combine existing health insurance schemes for civil servants and formal sector workers. The insurance benefits are in line with MPA and CPA packages.

UNIVERSAL COVERAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Cambodia has adopted policies and programmes in key areas to improve delivery of sexual and reproductive health services. Laws, standards and guidelines have focused on supporting universal coverage of maternal health services and contributed to a rapid increase in facility-based births and skilled birth attendance. The provision of family planning improved only slowly. Although the gap between wanted fertility and observed fertility closed from 0.6 children per woman in 2005 to 0.3 in 2015, it was still at the level of 0.6 among women in the poorest segment of the population in 2015, indicating that they had not achieved the desired access to family planning. Adolescent fertility rates are increasing, although this is more related to early marriage than to access to contraception. The unmet family planning need for limiting fertility among adolescent women aged 15 to 19 is quite low at 1.4 percent. [31],[33] Service coverage for prevention and treatment of cervical cancer and for addressing violence against women and girls is still insufficient and requires attention. [37]

Fixed and transparent user fees for sexual and reproductive health services provide some level of protection against financial hardship, especially as the fee levels are set in consultation with communities, and provisions are made for fee exemptions for the poor. All SRH services are included in the MPA or the CPA service packages provided at health centre or hospital level. The Health Equity Funds provide additional financial risk protection for the poor. The protection, however, does not extend to the private sector which delivers the majority of some sexual and reproductive health services, for instance for short-term family planning methods and for termination of pregnancy. The cost of health services is considered by two thirds of women as a barrier to access. There is little difference among age groups, but the financial barrier is higher for rural women and as high as 79 percent for women in the lowest wealth quintile. [33]

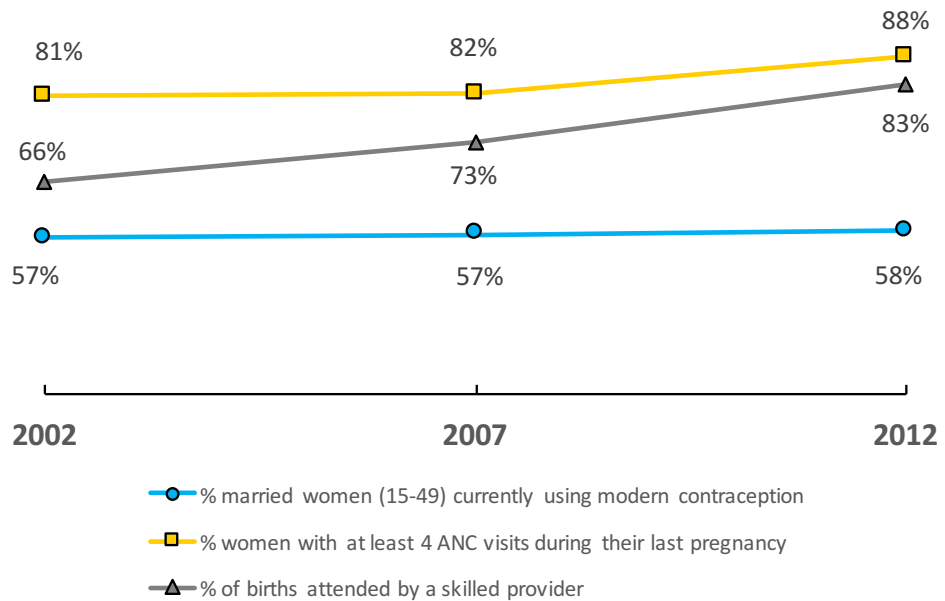
While Cambodia has achieved impressive progress in expanding the service offer for sexual and reproductive health after the almost complete break-down of health services under the Khmer Rouge regime in the 1970s and 80s, it has not yet achieved a high level of coverage of financial risk protection. Social equity instruments such as user fee exemptions and the current nationwide expansion of the health equity funds have contributed to narrowing some of the gaps in service utilisation between poor and rich. But since health equity funds are reimbursement mechanisms for health service expenditures, an important financial barrier to service utilisation remains.

INDONESIA



INDONESIA

TRENDS OF SELECTED SRH INDICATORS



Sources: [42],[43],[44]

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The population of Indonesia is served by a mix of public and private health care providers. Public health centres provide health promotion, immunisation, sanitation and health care services. The Indonesian health policy requires local governments to establish one public health centre for every 30,000 inhabitants and one sub-health centre for every 10,000. There are, however, large differences in service provision among provinces. A report in 2011 found that 25 percent of health centres country-wide were without a medical doctor, most of them in remote, poor provinces. [45]

Contraceptive prevalence rates in Indonesia are high and have been for many years. According to the most recent estimate, 81 percent of married women aged 15-49 have satisfied their need for family planning with the use of a modern method. [46] The difference between wanted and observed fertility in 2012 was 0.6 children per woman with little difference according to residence and social status. The total fertility rate of 2.6 has not changed since 2002. Family planning services are delivered by the Ministry of Health, and since 2016 they are included among the National Health Insurance benefits. Contraceptive commodities are supplied by the National Family Planning Board. Stock-outs of contraceptive supplies in health facilities and poor quality of family planning services have, however, become an issue of concern during the past three years. [47]

In 2003, the Ministry of Health started a programme to roll out the provision of **youth-friendly services** in primary health centres. About a quarter of health facilities are currently implementing the programme. However, the access of adolescents to sexual and reproductive health services remains limited. Guidelines for health providers stipulate that family planning services should only be provided to married couples. Adolescent fertility rates have remained unchanged over three rounds of DHS surveys between 2002 and 2012, each reporting that between nine and ten percent of women aged 15-19 had started childbearing. [44]

According to estimates by the FP2020 programme, there are approximately 2.6 million unintended pregnancies yearly. [46] Indonesia revised its general prohibition of **termination of pregnancy** in 2009 under the Law 36 on Health. In Article 75 the prohibition was lifted in case of a threat to the life of mother or foetus and for pregnancies due to rape. Among the requirements is the consent of both partners except in cases of rape. [48] The law continues to be restrictive and statistics about terminations of pregnancy are not available.

Indonesia made significant progress towards expanding **maternal health services**, however the 2015 Demographic and Health survey estimated a very high maternal mortality ratio of 359 deaths per 100,000 live births, an increase of more than 50 percent over the estimate in 2007. [44] In the subsequent strategic health plan (2015-2019), sexual and reproductive health was therefore flagged as a priority area. [49] There is evidence that with the launching of the National Health Insurance in 2014, health service usage and outcomes improved greatly, but available population-based data mostly predate the health insurance reform. Three subsequent DHS surveys documented relatively high coverage of some key reproductive and maternal health services with an increase in skilled attendance at delivery over the five years preceding the 2012 survey. The surveys document that between 2007 and 2012 about two thirds of women delivered their infants in a health facility. Most women chose private facilities, but the proportion of deliveries in public facilities already started to increase prior to 2012 (from 22% in 2002 to 27% in 2012). It is anticipated that the 2017 DHS will document further increases in deliveries in public health facilities.

Coverage rates of services for **sexually transmitted infections** are not known, however coverage of HIV positive pregnant women with anti-retroviral therapy for the prevention of mother to child HIV transmission (PMTCT) is low and has been falling. According to UNAIDS statistics it was 16 percent in 2012, falling to 9 percent in 2015. Indonesia is not a high HIV incidence country, but because of its large population there are an estimated 70,000 new HIV infections per year. [50] According to the 2013 Global STI Surveillance Report, syphilis testing during pregnancy was reported to be very low in Indonesia, at only 0.1 percent, in the context of a relatively high rate of positivity of 1.2 percent reported in 2009. [51]

Immunisation programmes against **Human Papillomavirus** exist only in a pilot phase. There is no information about the coverage rate. Indonesia has a national cervical cancer screening programme with a quality assurance structure and a mandate to supervise and to monitor screening. It does, however, not include an active invitation for screening, and coverage statistics are not provided. A small survey between 2007 and 2011 reported that 24 percent of participating women had undergone cervical cancer screening within the last five years. [52]

FINANCIAL RISK PROTECTION

In 2004, Indonesia launched a national social security reform with the development of a mandatory national health insurance as the first of five social security programmes. [11] In 2012, the 'Road Map towards National Health Insurance 2012-2019' was jointly developed by 14 national ministries and state agencies with a target to cover the entire population of Indonesia by 2019. [53] In 2014 a social security agency for health (BPJS) was established with the task of merging existing social protection and risk pooling schemes under a single National Health Insurance (JKN). Implementation started in January 2014 with 121.6 million members. The majority among them were social insurance beneficiaries whose premiums were paid by the State. Since then, there has been an increasing proportion of contributing members who joined the JKN through mergers of their civil servant, military, formal sector or private insurance scheme. By November 2016, membership was reported at 171 million, about two thirds of the population of Indonesia. Insurance claims in the 2015 calendar year were about 18 percent higher than in the first year of operation in 2014. [54]

Insurance benefits differ among different membership types and premium rates, but there are plans to gradually abolish these differences. Premiums start at 23,000 IDR per month (about 17 US\$) which is the subsidised rate paid by the State for the poor, and are set at five percent of family earnings for civil servants and other waged workers. For the self-employed and those working in the informal economy, three premium classes exist depending on the level of services subscribed.

The benefits of the National Health Insurance scheme launched under the BPJS-Health in January 2014 are generous, covering most of sexual and reproductive health services, and also covering some non-clinical costs such as ambulance referrals and hospital accommodation. Family planning services were included in 2016. Not covered are services for the termination of pregnancy except in special situations. Care for spontaneous abortion and post-abortive care are however included.

The JKN scheme is still in the process of expansion, undergoing adjustments of tariffs, benefit packages and premiums. According to key informants, it concluded its first year of operation with a negative balance, a deficit that increased in the second year. There are well-founded concerns about the capacity of government to fund the expansion. Some of the wealthier cities and districts have introduced pro-poor programmes to cover additional financial risks, for instance transport costs.

UNIVERSAL COVERAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Between 2014 and 2015, health service utilisation increased by 60 percent, but changes in service coverage for sexual and reproductive health are only just starting to be documented. While coverage for maternity-related services was already high or increasing prior to the introduction of the universal health insurance scheme, some services such as syphilis screening during pregnancy are lagging behind.

Access to SRH services for adolescents is restricted despite the launching of a youth-friendly service at the primary health care level. The restrictions are primarily related to service provider regulations and not to regulations of the National Health Insurance system.

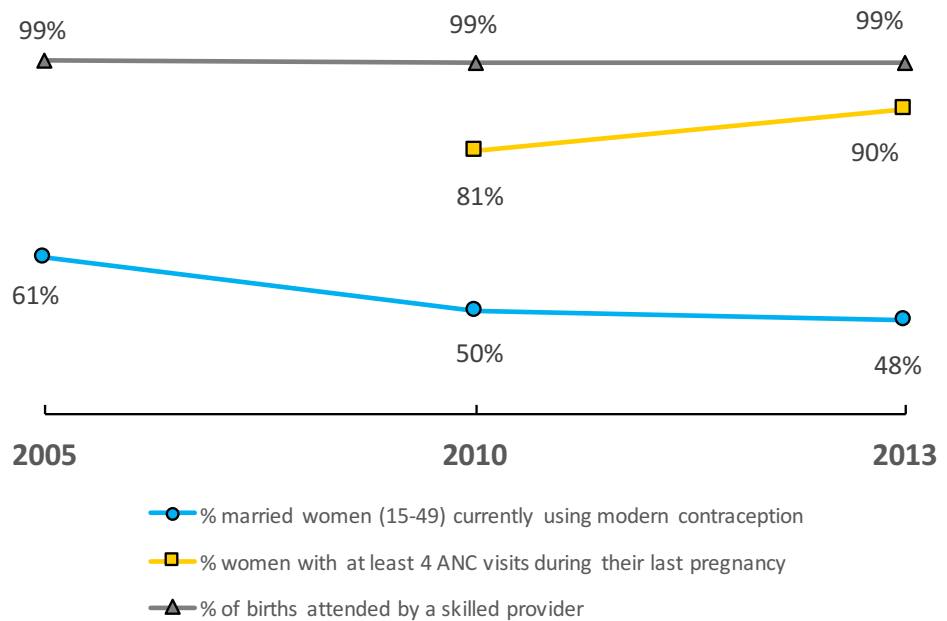
One of the main obstacles to overcome will be the regional inequity in service coverage. While the Capital Region of Jakarta recorded a satisfied demand for family planning of 82 percent and a rate of skilled assistance at birth of 99 percent, the corresponding metrics for the Province of Papua are 48 and 40 percent. [44]

MONGOLIA



MONGOLIA

TRENDS OF SELECTED SRH INDICATORS



Sources: [55], [56], [57]

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Health care at the primary level in Mongolia is provided by private and public health centres, secondary care by public hospitals and private clinics, and tertiary care by multispecialty central hospitals and specialised centres located in the capital Ulaanbaatar.

Contraceptive services in the public sector are provided at the primary and secondary level. In line with a national policy to promote population growth, the service delivery has deteriorated over the last ten years. Stock-outs of family planning commodities are common. Even in Ulaanbaatar, all facilities reported stock-outs of family planning commodities in 2015. The quality of service provision is low, with only 42 percent of those attending family planning services reporting that they received any counselling. [58] Contraceptive prevalence with modern methods has been decreasing since 2005, while the unmet need for contraception also started to decrease in 2010.

In parallel to the decreasing availability and use of contraceptives, the adolescent birth rate increased from 38 to 40 births per 1000 adolescent girls between 2010 and 2013. In contrast to the general decrease in the unmet need for family planning, the unmet need among adolescent more than doubled from 14 to 36 percent. The recently established adolescent health centres that provide counselling and services for sexual and reproductive health to young people also experienced shortages of contraceptive supplies. [58]

Termination of pregnancy in the first trimester is legal if performed in a health facility by a licensed medical specialist. Second trimester terminations require the permission of a medical committee. Between 2012 and 2013, an estimated 14 percent of pregnancies ended with an induced abortion. Among never married women the rate was 30 percent. [57]

Primary care facilities provide **antenatal care** and, in rural areas, also attend to normal deliveries. About 80 percent of deliveries, however, are attended in secondary level hospitals. Antenatal care coverage (90%) and skilled attendance at delivery (98%) are high, however the provision of services to migrants and mobile populations remains a challenge. [57] Mongolia made impressive progress in reducing maternal mortality from 199 deaths per 100,000 live births in 1990 to 26 deaths in 2015.[59] The national average, however, masks wide geographic and ethnic disparities. Seventy-five percent of all maternal deaths occur among herdswomen, the unemployed and unregistered migrants.

HIV testing is mandatory for antenatal care. More than 90 percent of women are tested, however only 32 percent reported that they were counselled. [57] By 2014, only seven HIV positive pregnant women had been diagnosed. Coverage rates for PMTCT services can therefore not be calculated. All anti-retroviral drugs are provided by the government and dispensed free of charge.

STI services are provided by public and private clinics. STI screening, including syphilis testing, is mandatory in antenatal care. The high incidence of sexually transmitted infections is a major concern. Between 2001 and 2013, the syphilis notification rate increased threefold from 71 to 222 per 100,000. Approximately one third of all cases of syphilis are diagnosed among pregnant women. One of the challenges of STI control is the high rate of self-treatment, often with inappropriate medications or doses. Despite MOH efforts, antibiotics are still dispensed without prescription. [60]

Cervical cancer ranks as the second leading cancer among women in Mongolia and is the most common cancer in women aged 15 to 44 years. About 320 new cervical cancer cases are diagnosed annually. [61] A national screening programme was launched in 2007 and reached a coverage of 29.7 percent in 2008. [62] HPV immunisation is being piloted in two provinces and two districts of Ulaanbaatar. [63]

Services for survivors of violence against women and girls are limited in the health sector. UNFPA has piloted the provision of integrated services for victims of violence through model one-stop centres in Ulaanbaatar and three provinces. [64]

FINANCIAL RISK PROTECTION

The health sector is financed from government resources, Social Health Insurance (SHI) premiums and out-of-pocket payments. With coverage almost consistently at 90 percent, the SHI has contributed to a stable financing source for the health sector. As a proportion of total health expenditures, however, government and SHI expenditures decreased between 1995 and 2014 from 82 to 55 percent, while the proportion of out-of-pocket expenditures increased from 17 to 41 percent. [6] The long-term health financing strategy is to reach universal health coverage with a mix of financing sources of public funds, health insurance funds, and out-of-pocket payments which are targeted to contribute about 25 percent to total health expenditure.

Health insurance in Mongolia is mandatory. The government fully subsidises the insurance premiums for about 60 percent of members. About 90 percent of SHI revenues are through payroll deductions and employer contributions for salaried employees. The premiums for children under 16, pensioners, mothers of children up to two years of age, and the poor are paid by government. All others pay a minimum monthly premium. Government subsidisation of the SHI premiums for students was removed in 2016. While the system is effective in collecting premium payments in the formal sector, it is not effective in raising contributions from people who are not formally employed. [65]

The government budget covers prevention activities, primary level health care services including for maternal and child health, treatment of cancer and diabetes and treatment of tuberculosis and HIV. The Social Health Insurance benefit package covers predominantly outpatient and inpatient care in secondary and tertiary public hospitals, traditional medicine clinics, sanatoriums and rehabilitation centres. Co-payment requirements at the secondary and tertiary level of care are 10 and 15 percent respectively. Accredited private hospitals can invoice services to SHI and are allowed to charge user fees at established rates. Outpatient medicines including contraceptives, diagnostic services above a monthly limit established by SHI, and a number of specified services, including therapeutic termination of pregnancy, are not covered by government or SHI and have to be paid for by patients.

This high share of out-of-pocket expenditures in health financing negatively affects equity, access and use of health services. The poor have difficulties accessing specific health services, including diagnostic tests and ultrasonography for pregnant women, even if they are insured by SHI. [66] Among the poorest quintile of the population, about 95 percent of household health expenditures are for the purchase of outpatient medicines. [67]

In 2009, an estimated 3.8 percent of households experienced catastrophic health care costs at more than 40 percent of their household subsistence income. [68] A more recent study found that this proportion had dropped to 1.1 percent in 2012, but an estimated 20,000 people were still forced into poverty by the cost of health care. [69]

UNIVERSAL COVERAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Mongolia has made impressive advances in reducing maternal mortality, increasing antenatal care and facility-based deliveries. However declining access and use of family planning, stock-outs of family planning commodities in public facilities, rising adolescent birth rates, high abortion rates, a high incidence of sexually transmitted infections and limited services for survivors of gender-based violence remain important challenges.

The government subsidises the health insurance contribution for poor and vulnerable groups, including mothers of children up to two years old and adolescents up to 16 years. There are, however, groups such as the former nomadic households, that are still uninsured.

Maternity care is provided free of charge at primary health facilities. More specialised services are covered by the Social Health Insurance at secondary and tertiary level facilities. Family planning services for most of the population, ultrasound and other advanced tests during pregnancy, termination of pregnancy, and out-patient prescription drugs are excluded from the SHI benefits, with the result that the individuals and families have to pay directly for many SRH services.

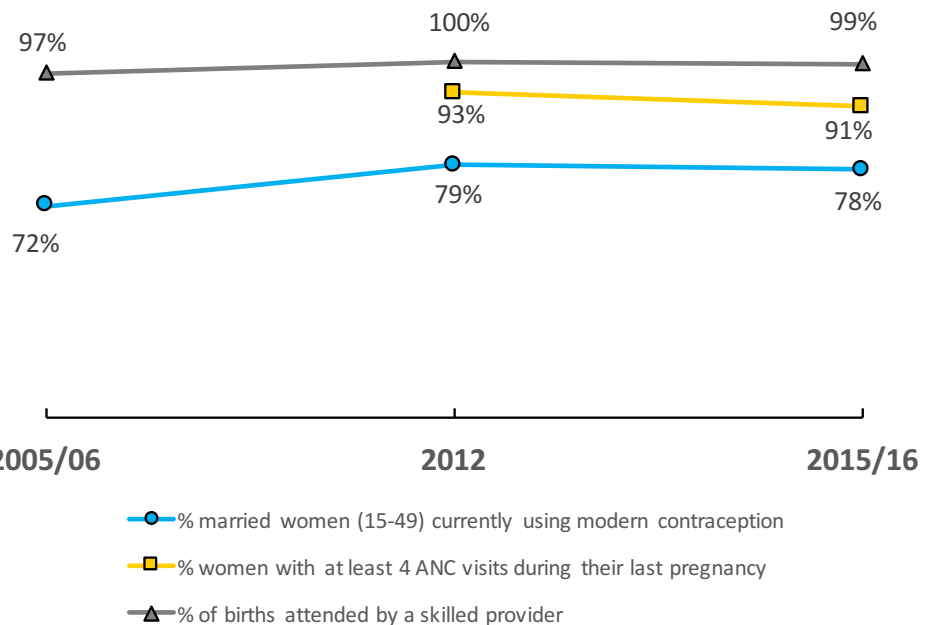
The access to SRH services by young people has increased with the creation of the adolescent health centres, but the initiative has yet to translate into documented SRH outcomes. Furthermore, the cancellation of government subsidies for the SHI premiums of students in 2016 may lead to an increase in the loss of health insurance coverage by young people over the age of 16 years.

THAILAND



THAILAND

TRENDS OF SELECTED SRH INDICATORS



Sources: [70],[71],[72]

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Health care in Thailand is provided by the public and private sectors. The public sector expanded rapidly in the 1960s under the National Economic and Social Development Plans, which emphasised the coverage of the entire country with a system of provincial hospitals, district hospital, and sub-district health centres. Private hospitals are primarily located in urban centres.

Thailand charted early advances in family planning. The contraceptive prevalence rate increased from 15 percent in 1969 to 74 percent in 1995 and reached a level of 78 percent in 2015. The total fertility rate fell from 6.8 children per woman in 1970 to 1.5 in 2015. Contraceptives are readily available, but a study in 2011 found that only a small number of public health facilities provided long-term reversible contraceptives such as IUDs and implants. [73]

Adolescent fertility is an area of concern in Thailand. Between 2000 and 2015, the adolescent birth rate increased from 30 to 51 births per 1,000 girls aged 15 to 19. It is considerably higher than the Asia-Pacific region's average of 35 per 1,000. One of the reasons are the marriage laws in Thailand that allow marriage at age 17. In 2015, 14 percent of adolescent girls aged 15-19 were married or in union, and four percent of them before the age of 15. [72] In July 2016, the 'Act for Prevention and Solution of the Adolescent Pregnancy Problem' came into force after approval by the National Legislative Assembly in February. It stipulates, among others, that adolescents aged between 10 and 20 years must be given access to reproductive health information and services. Furthermore, schools must offer age-appropriate sexuality education and provide counselling, support and protection for pregnant students to enable them to complete their education.

Termination of pregnancy is legal in Thailand if performed by a physician for the health of the woman, including her mental health, as well as in case of a pregnancy resulting from rape. The combination of Misoprostol and Mifepristone for medical termination of pregnancy was registered in 2015. Prescription is strictly controlled by Department of Health. [74] Each year, however, an estimated 300,000 to 400,000 illegal abortions are performed in Thailand. The continued high prevalence of unsafe abortions is thought to be due to a misconception in Thai society, including among health workers, that abortion is illegal in all circumstances, and due to personal and religious beliefs concerning termination of pregnancy. [75]

Thailand reached the MDG targets for **maternal health** well before the 2015 target date. In 2016, WHO certified that Thailand had eliminated **mother-to-child transmission of HIV and syphilis**. [76] Between January and October 2016, Thailand confirmed 392 cases of Zika virus infection, including 39 among pregnant women. Systematic testing of pregnant women for Zika virus infection is under consideration. [77]

Regulations requiring parental consent for **HIV testing** of adolescents under the age of 18 were revised in 2014 improving the access of young people to HIV prevention. Screening for HIV in antenatal care is universal. New infections with HIV have declined since 2000, and the HIV epidemic has become increasingly concentrated among key populations. Nevertheless, the prevalence of HIV among young people (15-24) has not decreased as anticipated. In 2014, it was estimated at 0.52 percent, compared to 0.58 percent in 2009. AIDS-related deaths declined sharply after the introduction of antiretroviral therapy (ART) in 2000, and have since stabilised. In 2013, about 80 percent of people living with HIV who were eligible for treatment received ART. In 2014, the eligibility criteria changed, and ART was offered to all people with HIV infection. The coverage rate, according to the new criteria, was 61 percent. [78]

Cervical cancer is the second most prevalent cancer among females in Thailand. [79] Screening was introduced in 1999 in a pilot project using a 'single visit approach' consisting of visual inspection with acetic acid and immediate treatment with cryotherapy if indicated. In 2003, the programme was scaled up country-wide. A study of coverage of the screening programme in 49 districts in 2008 reported an average coverage of 26 percent of eligible women, with some districts achieving a coverage of 45 percent. [80] Early detection of cervical cancer is increasing in Thailand with increasing diagnoses of in situ stage 1 and stage 2 cancers, and decreasing incidence of advanced disease.

The introduction of **Human Papillomavirus (HPV) vaccine** has been under discussion since 2008. Studies were conducted on the cost-effectiveness of the vaccine as well as on more efficient ways to deliver it. Current pilot immunisation programmes are planned to be gradually scaled up to nationwide coverage by 2020. [81]

Thailand adopted a law for the **protection of victims of domestic violence** in 2007 and established crisis centres in public hospitals at tertiary and community level. In 2013, the then Prime Minister officially launched a national network of 22,000 crisis centres and 1,300 mobile units managed by the Ministry of Social Development and Human Security. [82]

FINANCIAL RISK PROTECTION

In a major health sector reform in 2001, Thailand created the National Health Security Office [13] which became the central public purchaser of health services, allocating funds to public sector health facilities on the basis of catchment population and service provision. At the same time the Universal Coverage Scheme (UCS) was launched, a social health insurance aiming for national coverage. About 70 percent of Thais were already covered by one of four existing insurance or welfare schemes: the Social Security Scheme (SSS) for formal sector employees; the Civil Servants' Medical Benefit Scheme (CSMBS) for active and pensioned civil servants; the Medical Welfare Scheme which covered the poor, elderly, disabled and children under twelve years; and the Voluntary Health Card Scheme, a contributory health insurance with public subsidy for people in the informal sector. However, 18 million people, primarily informal sector workers in lower income groups, had no coverage. Out-of-pocket expenditures for health accounted for 33 percent of total health expenditure. UCS replaced the Medical Welfare and Voluntary Health Card schemes, and at the same time extended the coverage to all previously uninsured persons. It is fully tax-funded, offering a comprehensive benefits package with a focus on the primary care level.

By 2014, all Thai citizens were covered by a social or contributory health insurance scheme. Less than one percent of the population were not covered because they were foreigners or their citizen status was uncertain. [83] Out-of-pocket expenditure as a proportion of total health expenditure fell to eight percent in 2014. A review of the first ten years of UCS estimated that between 2004 and 2009 a total of 291,790 households were protected from impoverishment by the scheme. [84]

The **Social Security Scheme (SSS)** is a compulsory health insurance for employees in the formal private sector with contributions shared equally between employees, employers, and the government. In 2014, it covered approximately 11 million people. [83] The scheme provides a comprehensive health services package, including ambulatory care, medicines, dental care, hospital care, and maternity care. Contracted public and private hospitals are paid by capitation with additional payments according to utilisation rates. For services outside the contract hospitals, such as emergency care or dental care, beneficiaries are reimbursed according to established tariffs.

The **Civil Servant Medical Benefit Scheme (CSMBS)** is a fully tax funded fringe benefits for government employees, pensioners, and their dependents. In 2014, it covered approximately five million people. [83] The scheme provides a comprehensive health services package, including ambulatory care, medicines, dental care, and hospital care. Beneficiaries have free choice of public facilities. They can access private hospitals for inpatient care only in case of emergency and will be reimbursed up to a ceiling. Providers are paid on a fee for service basis.

The **Universal Coverage Scheme (UCS)** covers most of the remaining population, or about 48 million people. It provides a comprehensive health services package, including ambulatory care, medicines, dental care, and hospital care in registered facilities. HIV treatment services were added in 2009, and a programme for chronic disease care in 2010. The budget to finance the UCS has grown steadily from 46 billion Baht (1.1 billion US\$) in 2002 to 154 billion Baht (4.7 billion US\$) in 2014. Because of the overall growth of the government budget, proportional expenditures on UCS have been relatively stable in the region of six percent of the national budget. The total annual expenditure per registered beneficiary in 2014 was 2,895 Baht (approximately 89 US\$). [83]

Thailand is home to about 3.7 million migrant workers from neighbouring countries. [5] Migrants who work in formal sector employment and who are registered with the Social Security Office by their employer are insured under SSS. A much larger group of migrants are registered in the **Migrant Health Insurance (MHI)** scheme at a cost of 600 Baht (approximately 17 US\$) for an annual medical exam and 2,200 Baht

(approximately 61 US\$) for the annual insurance premium. Undocumented migrants, i.e. those without a work permit, are encouraged to join the MHI voluntarily. The scheme is managed by the MOPH. In 2014, there were 1.4 million migrants registered with the MHI. The benefits under MHI are comprehensive, and since 2013 also include anti-retroviral treatment for HIV infection. However, they are not portable, and tied to the hospital at which the annual medical examination was performed. [85] Undocumented migrants face barriers to enrol, such as the restricted portability of the coverage, the cost of the annual medical examination and policy renewal, and their general reluctance to identify themselves as migrants to the authorities. [86]

UNIVERSAL COVERAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Thailand achieved a high level of service coverage for health and for sexual and reproductive health with policies and programmes that started in the 1970s. The launching of the UCS social health insurance scheme in 2001 accelerated the progress and significantly closed the equity gap between social groups and regions. Impressive results were recorded in population and health indicators, including in family planning, maternal health, and the response to HIV. Three main health insurance schemes and an additional scheme for migrant workers provide financial risk protection for the entire population. Practically all SRH services are covered under the schemes, including HIV treatment and HPV immunisation which is planned to be scaled up to nationwide coverage. Universal coverage for sexual and reproductive health in Thailand is a reality today, financed primarily with general government revenues.

There are some areas that still require attention. Early marriage is common in Thailand and adolescent birth rates are higher than the regional average. The incidence of unsafe abortion is high despite relatively unrestrictive laws about termination of pregnancy and a social insurance system that covers the costs of therapeutic abortions. These are issues that cannot be addressed by the health sector alone.

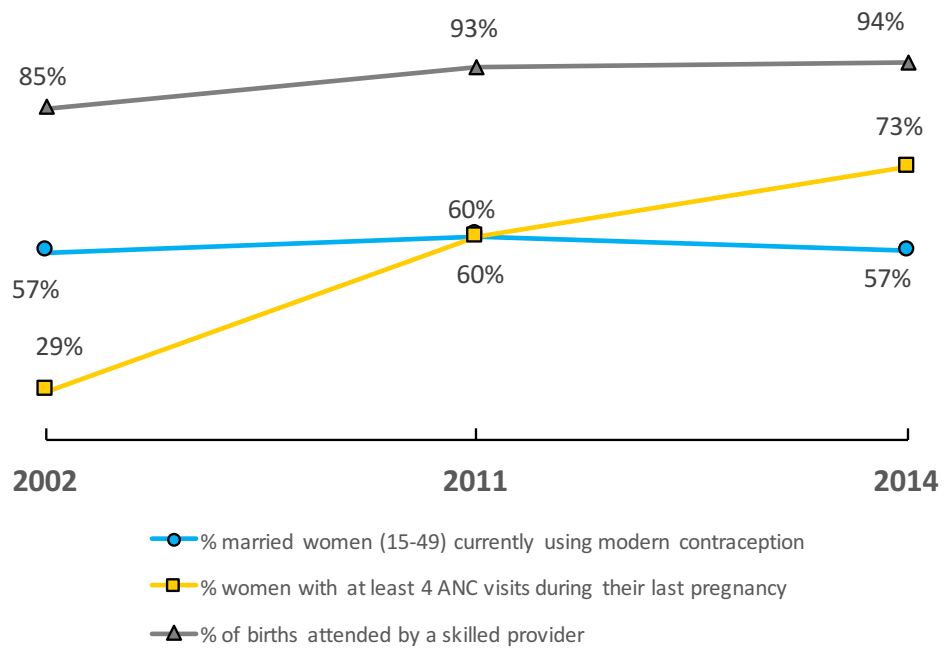
Although health services and insurance coverage for migrant workers in Thailand have improved greatly, there are still cultural, societal and financial barriers that prevent undocumented migrants from accessing SRH services. Migrant work is an important contributor to Thailand's economic growth, but the protection of the sexual and reproductive health and rights of the large number of undocumented migrants is lagging behind the rights that are enjoyed by Thai citizens and documented migrants. Further progress to ensure universal coverage for undocumented migrants will require collaboration with government sectors addressing migration and labour policies.

VIET NAM



VIET NAM

TRENDS OF SELECTED SRH INDICATORS



Sources: [87],[88],[89]

SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Ambulatory health services in Viet Nam are to 60 percent provided by the private sector, while inpatient care is to 96 percent in the public sector. [90] The public sector has a tiered structure from commune health centres at the primary level to national specialised hospitals at the tertiary level. While the quality and coverage of services for sexual and reproductive health have been increasing, the tertiary-level hospitals are overcrowded, and the service quality is under pressure. Provincial hospitals received significant government investments to improve the infrastructure, but they are experiencing bottlenecks of qualified human resources. Census and population survey data collected between 2000 and 2011 document a positive trend in the utilisation of sexual and reproductive health services, although there are persistent inequalities. [91]

Services for **contraception**, including family planning and emergency contraception are provided at all levels of the Viet Nam health care system. Adolescents and adults have access to these services. Services provided at the commune health centre level are limited, but more services are generally available in the district and provincial hospitals. Family planning services are not covered by the Social Health Insurance. Ethnic minority and poor families living in remote mountainous provinces, however, receive free family planning services funded by the National Population Programme. The contraceptive prevalence (any modern method) increased during the 1980s and 90s, but has been stable around 60 percent since the turn of the century. [92] It is higher among poorer women and among women in ethnic minority groups. The 2014 MICS reported a low unmet need for modern contraception of six percent among women who are married or in union, although the unmet need among married adolescent girls was considerably higher at 11 percent. [89] A national survey of adolescent sexual and reproductive health in 2016 reported a much higher unmet need of 24 percent among ever-married and 48 percent among never-married adolescents and women aged 15 to 24. [93]

The **adolescent birth rates** in Viet Nam in 2014 were 45 births per 1,000 girls aged 15 to 19 which is lower than in many neighbouring countries. The rate has, however, increased steadily from a low of below 30 prior to 2005. It is more than twice as high among girls in ethnic minority groups. [89]

There are no regulations prohibiting the **termination of pregnancy** before 12 weeks. After the 12th week, termination must be done in a hospital with surgical facilities and requires a prescription by a physician. Abortion rates in Viet Nam are high, but according to unpublished data of the national health management information system, they have recently fallen from 25 abortions per 100 deliveries in 2011 to 18 in 2014. This database may, however, miss a proportion of pregnancy terminations that are performed in the private sector. According to a survey among adolescents and young adults, six percent of pregnancies among adolescent girls aged 15-18, and nine percent among women aged 19 to 24 resulted in a termination. Among the 14 unmarried young women in the sample who had ever been pregnant, five terminated the pregnancy. More than half of the termination were performed in a private clinic or hospital. [93]

Maternal health services including antenatal, obstetric, and postnatal care, as well as treatment of obstetric fistulas and other health problems that may arise on the basis of pregnancy and delivery are provided at the appropriate level health care facilities. Micronutrient supplementation is provided as part of regular antenatal services but it is not covered by health insurance unless a deficiency is diagnosed. In 2014, the coverage of skilled attendance at birth was estimated at 99 percent among women from the main ethnic groups, but only at 68 percent among women from ethnic minority populations. The difference in antenatal care was even greater, with 82 percent of women of Kinh and Hoa ethnicity reporting four or more antenatal visits, while the proportion was only 33 percent among ethnic minority women.

Pregnant women who are at risk for **HIV infection** receive HIV testing and PMTCT services under the National HIV Prevention Programme (funded by government or international partners). Malaria is generally not a major public health problem in Viet Nam, but multi-drug resistant malaria was detected in the border region to Cambodia. Malaria prevention during pregnancy is not a routine service. Zika is an emerging infectious disease in Viet Nam. By November 2016, a total of 70 cases had been diagnosed. The National Institute of Hygiene and Epidemiology covers the cost for Zika testing, if required.

Specialised centres for **STI diagnosis and treatment** have been established in all provinces, providing treatment free of charge under the Social Health Insurance scheme. User charges apply to diagnosis and treatment of STIs in other public-sector facilities. Most patients, however, prefer to consult private practitioners. Since they do not report to the national health information system, data on the incidence and prevalence of STIs are limited.

The Ministry of Health has recommended to include immunisation against **Human Papillomavirus** in the list of regular public health services, but this has not yet been approved. Vaccines are available in most provincial immunisation centres. Cytology-based cervical cancer screening (PAP tests) is only available in district and provincial hospitals, and a small number of national and provincial hospitals offer screening by use of HPV DNA tests. [94] Cervical cancer treatment is provided in tertiary level facilities.

The health services have limited medical treatments options for women and girls who are survivors of gender-based violence, child abuse, and rape. They include emergency contraception and termination of pregnancy. There is no provision for psychological or social support. The Women's Union and the Ministry of Labour, Invalid and Social Affairs operates some pilot projects for survivors, funded by international organisations. However, these services are generally very limited.

FINANCIAL RISK PROTECTION

Universal health coverage was officially introduced in Viet Nam with the 2008 Health Insurance Law and updated in 2014 when membership in the national Social Health Insurance (SHI) scheme was made compulsory. SHI premiums for people in formal employment are paid through payroll deductions and employer contributions, for pensioners by the Social Security System, and for the poor, children under six and persons over 80 years of age by government. Others have to buy SHI membership which is subsidised in a range from 30 to 70 percent depending on income. In 2016, 82 percent of the population was covered by SHI. [95]

Health services for carriers of SHI cards are to 80 percent paid by SHI, with an out-of-pocket co-payment of 20 percent at the commune and district hospital level. Many patients, however, directly access provincial hospitals for primary care, with co-payment rates of up to 70 percent. Registered private health facilities can sign a contract with the SHI to offer services to SHI members, but individual private practitioners are not yet allowed to participate in the SHI scheme. Provider payment mechanisms vary according to the type of facility, including capitation and fee for service payment. Payment according to diagnostic-related groups is being piloted in some provinces. [95] The list of the SHI services and tariffs are developed and published by the Ministry of Health.

According to WHO estimates, out-of-pocket expenditures for health as a proportion of total health expenditures decreased steeply from 68 percent in 2005 to 37 percent in 2012, but have since stagnated around this level. [6] According to one study, out-of-pocket payments in state hospitals varied between 45 and 78 percent in 2014. [96] National experts interviewed for this report stated that a further decrease of out-of-pocket expenditures was unlikely, and an increase may even be seen in the near future, because SHI tariffs are not keeping pace with increasing costs of services.

In addition to SHI, a number of demand-side financing and provider performance incentive schemes are being piloted in Viet Nam. These are, however, implemented on a small scale, often in the private sector, and do not have a major impact on the overall delivery of SRH services.

UNIVERSAL COVERAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

The Social Health Insurance benefits in Viet Nam focus on curative clinical services and therefore do not cover many services for SRH. Almost all reproductive health services related to pregnancy and delivery are covered by SHI with a 20 percent out-of-pocket co-payment, which is higher when primary levels of care are bypassed. Pregnancy-related or co-existing health conditions are covered according to the existing tariff structure of the SHI.

Family planning services, termination of pregnancy, cervical cancer screening, HPV immunisation, malaria prevention, HIV treatment, Zika virus screening and micro-nutrition supplementation during pregnancy are not included among the SHI benefits. Some of these services are covered by special programmes or initiatives. These include the family planning programme for ethnic minority women and poor women living in remote provinces, as well as the HIV and malaria control programmes. Most of the specialised national programmes receive financial support from international partners. In recent years, this support has started to decrease. There are concerns that the programmes will start collecting user fees unless the services can be included among the SHI benefits.

Increasing adolescent birth rates and high rates of pregnancy termination should be a signal for an increased effort to provide access to effective contraception, especially to young people. The decision to exclude family planning services from the list of Social Health Insurance benefits therefore appears counterintuitive.

The diagnosis and treatment of sexually transmitted infections is covered by Social Health Insurance, but only if delivered by a specialised STI centre. Most individuals with STI symptoms, however, consult a private medical practitioner or a primary level public health facility and therefore have to pay for the service.

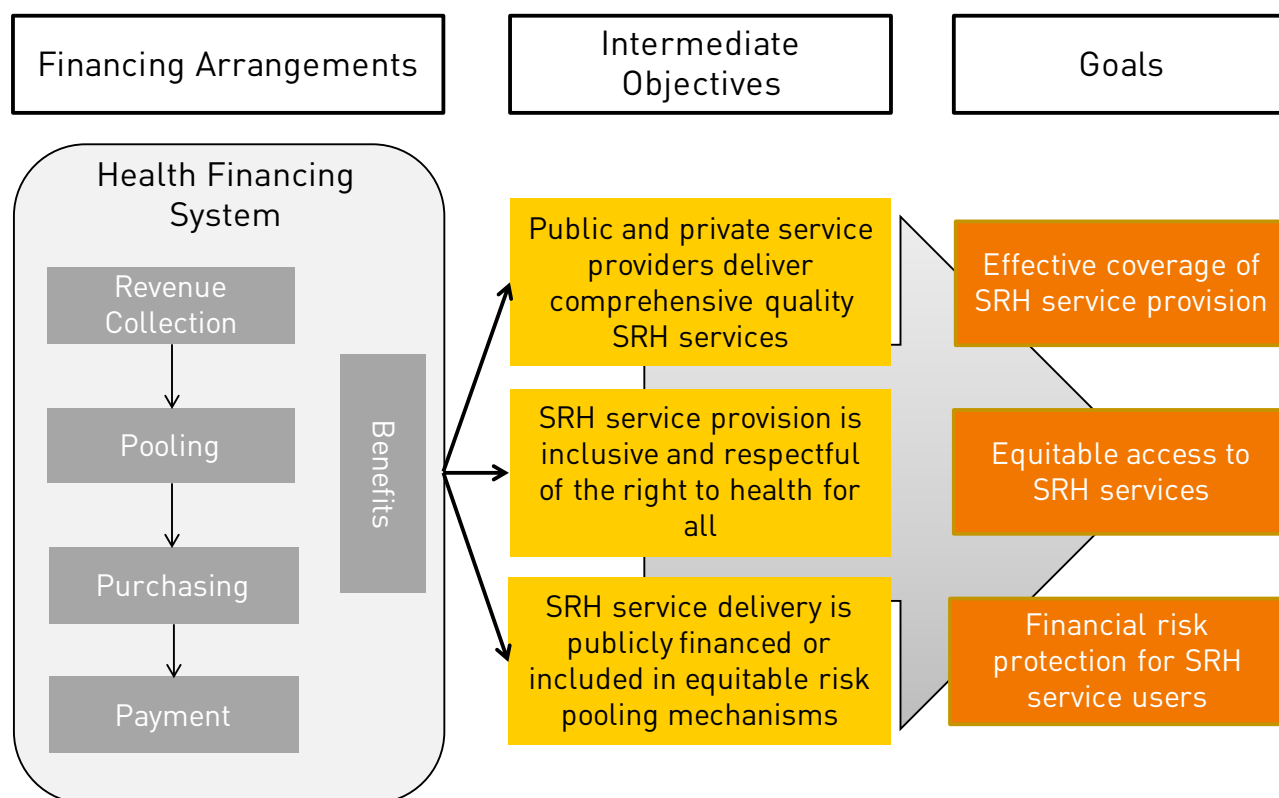
The success of targeted family planning programmes for ethnic minority populations documents that SRH service inequities for minority populations can be overcome, however they continue to exist in other areas of sexual and reproductive health, and especially for maternity care.

Considerable progress towards universal health coverage has been achieved in Viet Nam, but the coverage of sexual and reproductive health services is lagging behind. The Social Health Insurance is implemented in a very tight fiscal space, and choices have to be made about the coverage it can afford to provide. However, a more comprehensive coverage of SRH and preventive services would, in the longer run, avoid future costs of expensive clinical services and thereby contribute to consolidating and sustaining universal coverage.

UNIVERSAL HEALTH COVERAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

As the six country profiles document, there has been significant progress towards achieving the goal of universal health coverage for sexual and reproductive health services in the Asia-Pacific Region. Not surprisingly, progress is not achieved at the same speed and in the same components of the UHC goal in all countries. There are major cultural, social, economic and political differences, including among low- and lower-middle income countries. In order to analyse the differences and generate common lessons, the goal was disaggregated into its three components: Effective service coverage, equitable access to services, and financial risk protection for users of the services.

CONCEPTUAL FRAMEWORK FOR UHC IN SEXUAL AND REPRODUCTIVE HEALTH



Adapted from [97]

The conceptual framework describes the necessary elements for achieving universal coverage for sexual and reproductive health. It has major limitations because sexual and reproductive health is not only dependent on health services. It is to an even greater degree dependent on the social context, the general level of social protection, social cohesion, gender equality, and the respect of human rights, including children's rights. The extent to which people are able to realise their right to sexual and reproductive health depends on policies and their implementation in many sectors, including education, justice, family, women, welfare, labour and immigration. This cannot be fully captured in a framework that focuses on health services. Nevertheless, universal coverage of sexual and reproductive health services is a goal that contributes significantly to sexual and reproductive health and the realisation of sexual and reproductive rights.

EFFECTIVE COVERAGE OF SRH SERVICES

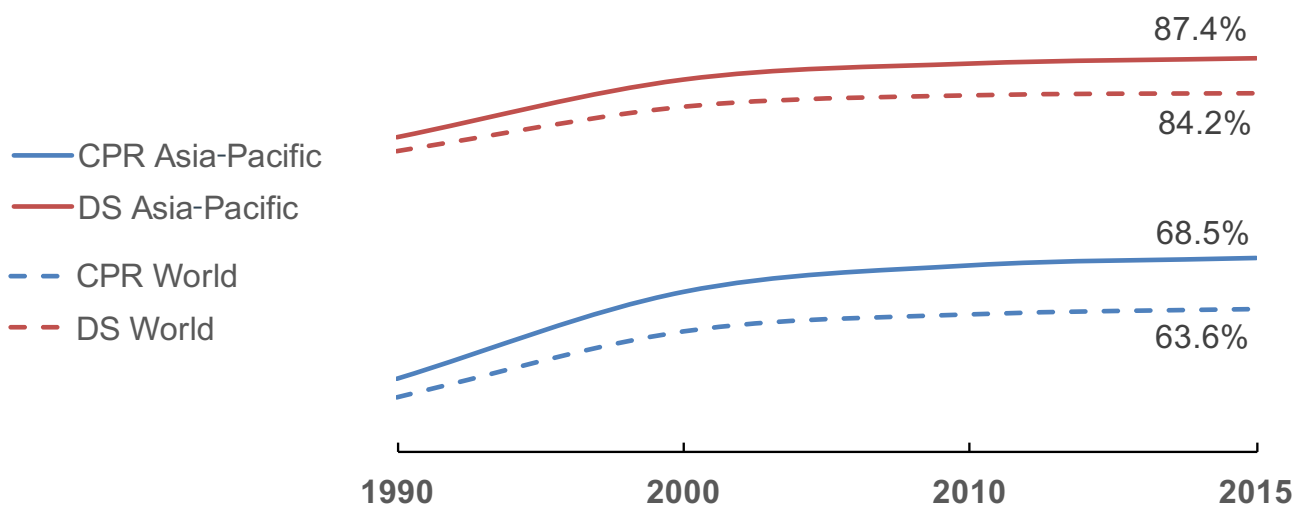
CONTRACEPTION AND TERMINATION OF PREGNANCY

Fertility and contraception

Between 2010 and 2015, after four decades of steady decline, the global total fertility rate (TFR) was estimated at 2.5 children per woman. The decline has even been faster in the Asia-Pacific Region. Starting from a TFR of above 5.5 in 1970-1975, the region achieved a rate of about 2.2 by 2010-2015. Several populous countries in the region are now experiencing fertility rates that are lower than the population replacement level of 2.1, notably Thailand (1.5), China (1.6), Iran (1.7), Malaysia (2.0) and Viet Nam (2.0). The region does, however, also include countries with fertility rates that are well above the global average, such as Afghanistan (5.1), Pakistan (3.7) and several of the Pacific Island States. [98] In Mongolia, the total fertility rate has been increasing steadily from 2.5 in 2003 to 3.1 in 2014, consistent with government policy to encourage population growth. [58]

The region's success in addressing the challenges of rapid population growth can primarily be attributed to the expansion and promotion of family planning services. While these were primarily motivated by population control objectives, they also contributed to an increased realisation of sexual and reproductive health and rights. The contraceptive prevalence rates (CPR) and the proportion of satisfied demand for family planning (DS) among women in Asia-Pacific aged 15-49 who are married or in union have been consistently higher than the global average since the 1990s. [99]

Contraceptive prevalence rate and satisfied demand for family planning in the Asia-Pacific Region and globally 1990 - 2015



Source: [99]

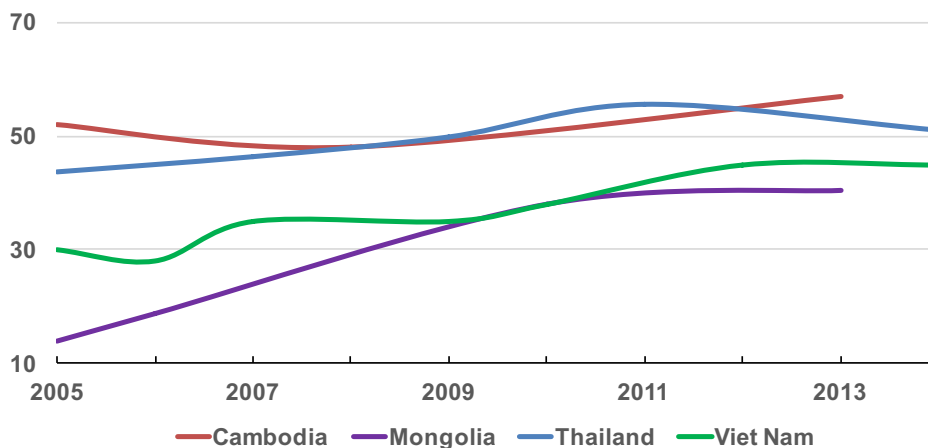
Some countries are left behind in meeting the demand for contraception. They include Afghanistan (52% of demand satisfied), Timor Leste (53%), the Pacific Island States (between 43% in Samoa and 64% in the Solomon Islands), and Pakistan (65%). The fact that 84 percent of women in Bangladesh can satisfy their demand for contraception is remarkable, considering that it is among the economically most disadvantaged countries in the region. It should, however, also be kept in mind that despite the high level of coverage achieved in Bangladesh and in the other populous countries such as China (96%), Indonesia (85%) and India (82%), the number of women who are not able to meet their demand for family planning in these countries is very high because of the large population size. [99]

Adolescent fertility

The age of physical, sexual and mental maturity varies greatly among individuals. Pregnancy at young age, however, often deprives girls of opportunities to fully develop their potential in social, economic and emotional terms, and generates higher than average risks of experiencing untoward outcomes, including stillbirths and maternal deaths. Pregnancies among adolescent girls are also more likely to be unintended, often resulting in unsafe abortions and adding an additional risk to the reproductive health of young women. When discussing adolescent fertility, a distinction must be made between girls who are married and in union, and those who are unmarried and sexually active. The two groups have different reproductive health needs, require different types of services, and different prevention strategies. These strategies are, to a very large extent, outside the remit of the health sector. Early pregnancy and child bearing are issues that concern women's and children's rights, child protection, gender equality, sexuality education, and civil registration of births and marriages. Health services, where the risks of early pregnancy become evident through the complications at birth or after abortion, can contribute to prevention by providing adolescents access to contraception, safe termination of unintended pregnancies and post-abortion care, and they can reduce the risks of childbirth by providing maternity services that are adapted to the needs of adolescents.

According to the most recent survey data between 2005 and 2014, an estimated 24 percent of adolescent girls in Asia-Pacific were sexually active, slightly less than the global average of 26 percent. The great majority among them (99%) were married or in union. The regional adolescent birth rate between 1991 and 2015 of 35 births per 1,000 girls aged 15 to 19 was considerably lower than the global estimate of 52. However, because of the large population, the region accounted for one third of all births to adolescents in 2015, an estimated 5.2 million out of a total of 15.2 million. [99] While globally, and especially in Asia-Pacific, adolescent birth rates have been falling for two decades, survey data from the last ten years in four of the six sampled countries show increasing trends.

Adolescent birth rates (per 1,000) in selected countries



Source: [100]

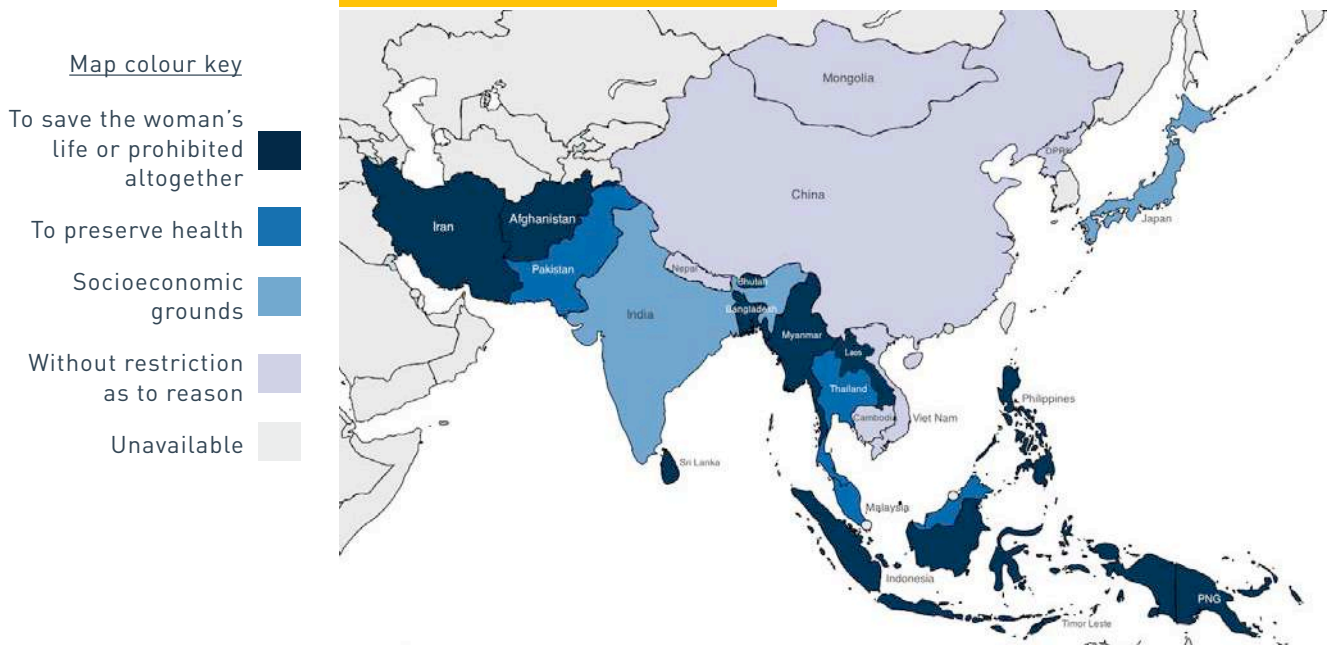
According to UNFPA estimates, only about one percent of sexually active adolescent girls in Asia-Pacific are unmarried, but only one in five of these girls are protected from unintended pregnancy, most of them by the use of male condoms. Only six percent of them use a female-controlled method of contraception. [99] This points to a major gap in coverage of contraceptive services for this group of adolescents which is at high risk for resorting to unsafe terminations of their pregnancy. A review of induced abortions in Thailand published in 2004 reported that among the women who had resorted to an illegal abortion, the proportion of adolescents was 30 percent. One third of these abortions had resulted in serious complications. [101]

Termination of pregnancy

In many countries of the Asia-Pacific regions, the laws on the termination of pregnancy are restrictive as illustrated in the map.

- The laws in the countries coloured in dark blue prohibit abortion, with the exception to save a woman’s life although this may not be explicitly mentioned in the legal text. These countries also include the Maldives and the Pacific Island States which are not marked on the map.
- In Pakistan, Thailand and Malaysia abortion is permitted to preserve a woman’s health, whereby this also includes mental health in Thailand and Malaysia
- Additional legal permissions for social and economic reasons are granted in Japan and India
- Only six countries, Mongolia, China, DPR Korea, Nepal, Viet Nam and Cambodia permit unrestricted access to abortion within gestational limits that vary among countries.

ABORTION LAWS IN ASIA-PACIFIC 2014



Source: [102]

In Bangladesh, termination of pregnancy is illegal except to save a woman’s life, however menstrual regulation (MR) has been part of Bangladesh’s national family planning programme since 1979. MR does not require a confirmation of pregnancy and involves the manual vacuum aspiration of uterine content or the oral administration of a combination of mifepristone and misoprostol to provoke menstrual bleeding (MRM). Government regulations allow MR up to 10–12 weeks and MRM up to nine weeks after a woman’s last menstrual period. [103]

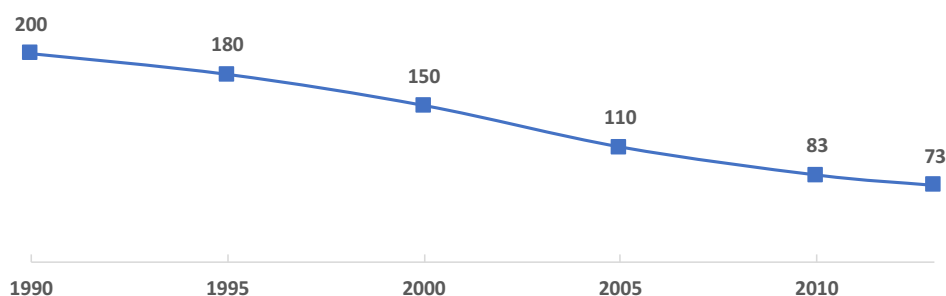
While access to medical termination of pregnancy can contribute to women’s realisation of their sexual and reproductive health and rights, sex-selective abortions are performed because of social preferences for male offspring and are a practice that violates women’s rights. Although they are illegal in many countries, including in China and India, they are practiced widely as documented by the higher than biologically plausible ratio of male to female births², especially in China (116/100), Viet Nam (112/100), India (110.9/100) and Pakistan (108.7/100). [98]

² The biological sex ratio at birth is around 104 to 106 boys per 100 girls

MATERNAL HEALTH SERVICES

The Asia-Pacific Region made significant progress in expanding access and utilisation of maternal health services. This is best documented in the trend of the maternal mortality ratio (MMR). Although the achievements fell short of the MDG target of a 75 percent reduction between 1990 and 2015, the ratio did decline by about two thirds.

Maternal deaths per 100,000 live births in South East Asia, East Asia & Oceania 1990-2013*



*largely congruent with the UNFPA Asia-Pacific Region

Source: [104]

The summary statistic, however, hides very large differences among countries. Among the six countries included in the study, for instance, there is almost a nine-fold difference between the estimated maternal mortality ratios in Thailand and in Bangladesh.

The quality, access and use of antenatal, obstetric, and postpartum care are key determinants of maternal mortality. Additional determinants of equal importance are not within the remit of the health sector. They include, for instance, the status of women, the level of gender violence and the level of adolescent fertility. Recent survey statistics on the coverage of maternal health services in the six study countries show that the countries with high service coverage generally have low maternal mortality ratios. But there is no direct correlation and there are exceptions. Cambodia and Viet Nam, for instance, have a similar level of maternal health service coverage, but a three-fold difference in maternal mortality. Improvements in services will not immediately be reflected in maternal mortality statistics which are usually calculated over a period of several years. Other reasons may be related to uneven quality of services provided. But these differences are also a reminder that health is not just an issue of health service coverage.

Antenatal care (at least 4 contacts), skilled attendance at birth, postnatal care within 48 hours of delivery and estimated maternal mortality ratio (maternal deaths per 100,000 live births)

	ANC x 4	SBA	PNC (48 hrs.)	MMR*
Bangladesh	31.2 %	42.1 %	36.4 %	176
Cambodia	75.6 %	89.0 %	90.3 %	161
Indonesia	87.8 %	83.1 %	80.1 %	126* / 359#
Mongolia	89.6 %	98.9 %	95.4 %	44
Thailand	90.8 %	99.1 %	N/A	20
Viet Nam	73.7 %	93.8 %	89.8 %	54

*estimates of the UN Maternal Mortality Estimation Inter-Agency Group

the estimate of the 2012 DHS survey is considerably higher than the estimate of the UN Inter-Agency Group

Antenatal care

In 2016, the WHO replaced its recommendation for at least four antenatal visits during pregnancy with a recommendation for a minimum of eight contacts. [105] However only the coverage of four or more ANC contacts is currently being monitored. In developing countries globally, it increased slowly between 1990 and 2014, from 35 percent to 52 percent. South East Asia, however, took a leap forward from 45 percent to 84 percent, while South Asia lagged behind with an increase from 23 percent to only 36 percent. [106] This split within the Asia-Pacific Region is also reflected in the statistics of the six sampled countries. But national statistics hide significant inequities in coverage among regions and social groups within the country.

Statistics about the frequency of antenatal care contacts do not provide information about the content and quality of care. Comprehensive assessments of the quality of care are only available from occasional evaluations of geographically limited programmes. In Demographic and Health Surveys (DHS) women are asked whether they received iron supplements during their pregnancy. Affirmative responses recorded in recent surveys range from less than 50 percent in Pakistan to more than 95 percent in Cambodia. [107], [33]

One component of antenatal care is the prevention and management of pregnancy-related or concurrent diseases. Comparable national statistics are only collected for health conditions that are covered by international programmes or global health initiatives. These include malaria, HIV infection and syphilis. Increasingly Zika virus infection is receiving attention, but screening for Zika virus is not systematically included in national ANC protocols of the six countries in the sample.

According to data collected by UNAIDS, about 7,500 pregnant women in five of the six sampled countries received antiretroviral treatment for HIV infection during pregnancy in 2015. [50] Most of these women were in Thailand, which achieved more than 95 percent coverage of antiretroviral treatment among pregnant women living with HIV. In June 2016, WHO certified that Thailand had eliminated mother-to-child transmission of HIV and syphilis. [76] Viet Nam achieved about 58 percent coverage, but in Indonesia the coverage was only estimated at nine percent and in Bangladesh at 14 percent. In Mongolia, only two women were reported on treatment, but because of the low HIV prevalence this was estimated to represent a coverage of 50 to 95 percent. Data from Cambodia were available for 2013 only, with 691 women on treatment and an estimated coverage of about 60 percent. [108]

Data on coverage of syphilis screening and treatment at first ANC contact are available from the WHO Global Health Observatory database for most countries of the region. [109] Coverage rates above 95 percent were recorded for China, Mongolia, Bhutan, Thailand and several Pacific Island States. Some countries in Asia-Pacific, however, had very low coverage rates such as Indonesia (0.5%), Myanmar (12.4%), Bangladesh (31.6%), and Cambodia (41.2%).

Obstetric and emergency obstetric care

Skilled attendance at birth (SBA), i.e. the attendance of a doctor, nurse or midwife at the time of delivery, can potentially prevent obstetric complications and adverse outcomes. It is, of course, also essential that professionals who are classified as 'skilled' are trained in the management of labour and delivery, and have the necessary medicines and equipment to deal with obstetric emergencies. The SBA coverage more than doubled over the past five to seven years in some Asia-Pacific countries, for instance in Bangladesh, Cambodia and Nepal, but it is still less than 50 percent according to the most recent surveys in Afghanistan, Bangladesh and Laos, and it is only a first step towards improved maternal care.

The next important step is the access and use of emergency services in case of complications. The extent to which health systems are equipped to respond to obstetric emergencies is assessed in national surveys of emergency obstetric and neonatal care (EmONC). Ministries of Health often have statistics on the number of facilities that are classified as providing basic or comprehensive EmONC. Studies of the functionality of these facilities, however, usually report significantly lower numbers.³

Cambodia assessed emergency obstetric care facilities in 2015 in preparation of the EmONC Improvement Plan 2016-2020. The country had made significant progress during the implementation of the preceding plan. The number of functional facilities providing basic emergency care had increased from 19 to 110, and for comprehensive emergency care from 25 to 37. The proportion of births in functional facilities had more than doubled since 2008. However, the facilities providing comprehensive care were primarily concentrated in urban hospitals, while the overall density of emergency care facilities was still less than half of the recommended level of one per 100,000 population. Furthermore, an in-depth assessment of basic EmONC facilities revealed that of the 110 listed facilities, only 28 were fully functional according to the established criteria. [110]

Postnatal care

Postnatal care is recognised as a key intervention to save the lives of newborn infants. The evidence for its impact on maternal health is less clear, but about 40 percent of maternal deaths occur between the second and the seventh day after delivery, primarily from infection and postpartum haemorrhage. [111] Postpartum check-ups within the first 48 hours after delivery that focus on the mother and not only on her newborn infant are therefore considered important interventions for maternal health.

Recent DHS and MICS surveys have included questions about postnatal check-ups of mothers within 48 hours after delivery. Survey data from the Asia-Pacific Region are only available from a few countries, and there are even fewer data on trends. As can be expected, an increase in deliveries in health facilities also resulted in increased coverage of post-partum check-ups. The coverage of post-partum care for mothers in each country is therefore comparable to the proportion of births in health facilities.

PREVENTION AND TREATMENT OF SEXUALLY TRANSMITTED INFECTIONS

The global prevalence, incidence and treatment of HIV infection is monitored by UNAIDS through regular reports submitted by countries to the global AIDS response reporting mechanism. For four other sexually transmitted infections, gonorrhoea, chlamydia, trichomonas and syphilis, the global situation is estimated every five years by WHO based on national studies and surveillance reports. The latest available regional estimates of STI incidence are for 2012. [51]

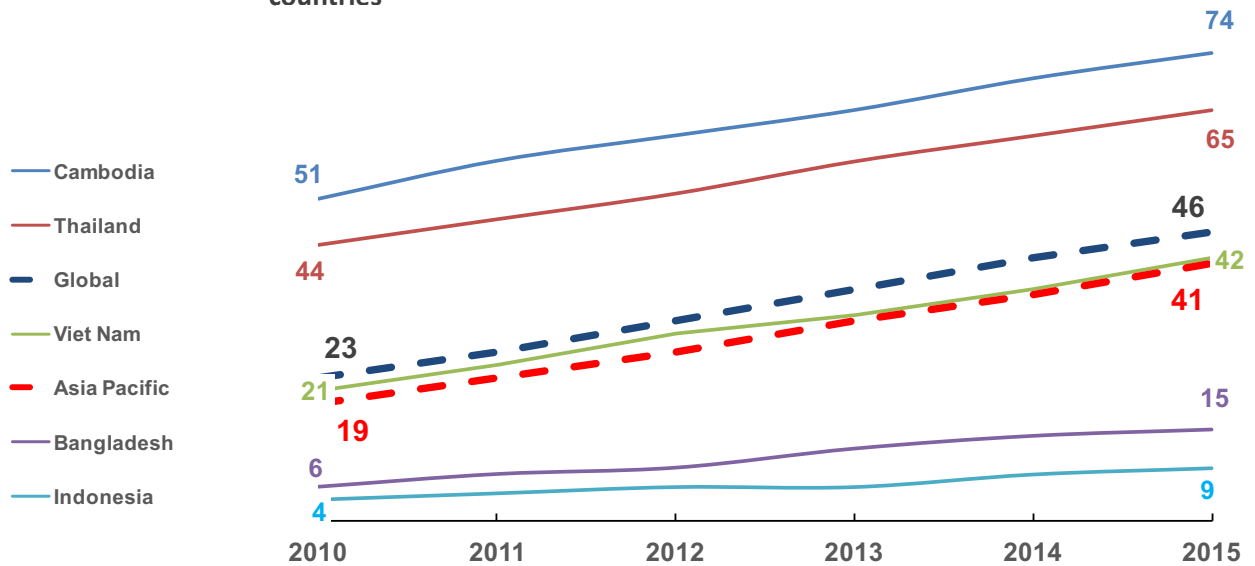
According to UNAIDS, there were 300,000 new HIV infections in Asia-Pacific in 2015. [112] In 2012, the combined incidence of the four other STIs in the WHO regions of South-East Asia and Western Pacific⁴ was 181 million. [113] The incidence rate of HIV infections in the region has always been low compared to other regions, and has fallen by more than 50 percent since the late 1990s. The incidence rate of the other four STIs, however, was generally above the global average and does not show the same declining trend. In Mongolia, for instance, the syphilis notification rate more than doubled between 2001 and 2011. [114] Because of its large population size, the Asia-Pacific Region accounted for 14 percent of global HIV incidence in 2015, and for 51 percent of the combined global incidence of gonorrhoea, chlamydia, trichomonas and syphilis. [113],[50]

³ Functionality for a basic care facility is defined as having performed each of seven 'signal functions' at least once within the last three months, with the addition of surgery and blood transfusion for a comprehensive care facility (WHO, 2009)

⁴ The two WHO Regions combined correspond roughly with the UNFPA Asia-Pacific Region

An estimated 41 percent of people living with HIV in the Asia-Pacific Region received anti-retroviral treatment in 2015, less than the global average of 46 percent but within the same estimation range. In the countries of the study, as well as regionally and globally, there has been an almost linear increase in the proportion of people on treatment, albeit at different speeds and levels. There is a large spread in treatment coverage, with 74 percent of the estimated number of people living with HIV on antiretroviral treatment in Cambodia and only nine percent in Indonesia in 2015.

Estimated antiretroviral treatment coverage (% on treatment) in selected APR countries



Source: [50]

The offer of health services for diagnosis and treatment of STIs has also greatly expanded since the 1990s, aided by the introduction of syndromic management in many countries of the region. Syndromic management allowed a decentralisation of STI services to the primary health care level and the provision of diagnosis and treatment in a single consultation. [e.g.115] There are, however, still barriers of access to treatment that are related to societal attitudes or to the way the treatment services are organised.

In 2010, for example, a survey of young people at risk⁵ in Cambodia found that only 36 percent of young women and 41 percent of young men with symptoms of a sexually transmitted infection sought treatment in a public or private clinic. Most of them did not seek any treatment, and a smaller number resorted to self-medication or traditional medicine. [116] In Viet Nam, treatment for STIs that is covered by social health insurance is only available at specialised Venereal Prevention and Control Centres. Many people, especially adolescents, avoid these centres and instead pay for services or resort to self-medication.

PREVENTION AND TREATMENT OF CERVICAL CANCER

Cervical cancer is the fourth most common cancer in women with an estimated 528,000 new cases and 266,000 deaths globally in 2012. About half of the incidence, 269,000, and half of the deaths, 137,000, occurred in the Asia-Pacific Region. [117] The lifetime risk of cervical cancer among women aged 15 to 79 varies greatly, from below one percent in the Maldives, China, Sri Lanka and Pakistan to between three and six percent in the Pacific Island States. [118]

The role of health services in the prevention and treatment of cervical cancer comprises three interventions:

- Primary prevention: Immunisation against Human Papillomavirus (HPV)
- Secondary prevention: Screening and treatment of precancerous lesions
- Tertiary prevention: Treatment of invasive cancers and palliative care

⁵ including sex workers and clients, injecting drug users, and men who have sex with men

HPV immunisation

Infection with Human Papillomavirus is one of the most common sexually transmitted infection in the world. A study in 2007 estimated that 291 million women were carriers of HPV DNA. [119] Three HPV vaccines have been licensed since 2006, all protecting against HPV16 and HPV18, the types of HPV that are associated with 70 percent of invasive cervical cancers in Asia. [120] Since 2014, WHO recommends a two-dose vaccination regime for girls aged 9 to 13, but many countries still apply the older three-dose regime. [121] In the Asia-Pacific Region, only Bhutan, Malaysia and several Pacific Island States have introduced HPV vaccination in their national immunisation programmes.⁶[122]

The Gavi Alliance provides financial support for the introduction of HPV immunisation to low and lower-middle income countries that have met defined capacity criteria. By 2015, Bangladesh, Lao PDR, Nepal and the Solomon Islands had applied for Gavi support. In other countries, pilot initiatives for HPV immunisation were implemented with other international support, for instance in India and Viet Nam with support from PATH International. In a demonstration project in four districts in Viet Nam, 6,358 eleven-year-old girls (91% of eligible girls) were immunised during a two-year period. [123] The introduction of HPV vaccine in the national immunisation schedule in Viet Nam is under discussion.

Screening for cervical cancer and treatment of precancerous lesions

Screening programmes for cervical cancer using cytological testing or visual inspection after acetic acid application (VIA) have been launched in many countries, and more advanced methods such as HPV DNA testing are being piloted. Many countries also introduced a single-visit approach for diagnosis and treatment, combining VIA screening with cryotherapy, especially in rural health facilities. Networks of colposcopy centres for referral and further treatment of women with abnormal cytology or VIA results have been established. The status of development of these services varies from country to country.

Cervical cancer screening in selected APR countries

	Programme	Source
Bangladesh	National screening programme launched in 2005. Recommendation to screen women over 30 every three years with VIA. Screening centres in 238 health facilities country-wide. Colposcopy centres in medical college hospitals. Participation is moderate with about 100,000 women screened each year. Recent information on screening coverage is not available.	[125]
Cambodia	National programme in planning. Several pilot projects in operation using VIA and single-visit VIA/cryotherapy approach. A screening programme linked to the reproductive health voucher project screened 30,000 women between October 2014 and May 2016. A study of a small sample of 309 women in 2013 estimated a national coverage of 19.7%	[125]
Indonesia	National screening programme launched in 2007. Recommendation to screen women aged 30-50 every five years. Services for single-visit VIA screening and cryotherapy are currently available in 347 primary health centres in 23 provinces. Coverage between 2007-2011 was estimated at 24.4%.	[124] [126] [127]
Mongolia	National screening programme launched with the National Cancer Control Programme 2007-2017. Objective to screen women aged 30-60 every year using VIA. Coverage in 2008 was estimated at 29.7%.	[62] [128]
Thailand	National screening programme launched in 2005. Recommendation to screen women aged 30-60 every five years using cytological screening. VIA, including the single-visit approach, is used in remote districts. HPC DNA testing is being piloted. Screening centres are linked to colposcopy services. Coverage in 2009 was estimated at 60.2%	[124] [127] [129]
Viet Nam	National screening programme launched in 2011. Recommendation to screen women every two to three years with focus on the 30-50 age group. VIA and cytology are used. HPV DNA testing is available in only a few national and provincial hospitals. Recent information on screening coverage is not available	[130] [94]

Services for cervical cancer screening as well as for treatment of pre-invasive and invasive cervical cancers are only just starting to be scaled up into national programmes in most Asia-Pacific countries. Overall, the health service coverage for the prevention and treatment of cervical cancer in Asia-Pacific has major gaps at all levels. Very few countries are providing acceptable levels of services for primary prevention and early detection through their public health system.

⁶ Marshall Islands (2008); Federated States of Micronesia, Palau (2009); Bhutan, Malaysia (2010); Cook Islands, Kiribati (2011); Fiji (2013)

Health services for gender-based violence

Gender-based violence (GBV) is based on gendered role expectations and unequal power relationships. Although it can be directed against men and boys who do not comply with social gender norms, it is overwhelmingly violence directed against women and girls. [131] Like many issues of sexual and reproductive health it is not just a health sector issue. The responsibility for policies to prevent GBV is rarely within the mandate of Ministries of Health. Services to respond to violence, once it has happened, may be located at health facilities, but are not always under the authority of the Ministries of Health. However, after an incidence of violence, health facilities are most often the first contact points where the physical and psychological consequences can be established and addressed.

Gender-based violence as a public health issue is a complex theme that has been discussed in great detail in numerous fora and publications. In 2010, UNFPA published a detailed assessment of the situation in the Asia-Pacific Region, describing the laws, policies, their application, as well as policy and service initiatives to strengthen the health sector response to GBV. [132]

Public health initiatives to prevent GBV, however, are not activities that generate personal user charges. An assessment of universal health coverage for sexual and reproductive health can only provide a sketch of service availability and access, and review the systems for protecting women from financial risks when accessing them. Although there are occasional reports that injured women are charged for health services in some countries, [e.g. 133] cost is not the most formidable barrier to services for women who have experienced violence. The availability and comprehensiveness of services and referral networks, the attitudes of providers, and the protection of the woman's safety and dignity are of much greater importance.

Several countries in the region have established One-Stop Crisis Centres (OSCCs) in public hospitals. In addition to medical care and counselling, they offer social and legal assistance and referral to shelter. These centres have been well integrated in the national health systems in Indonesia, Malaysia, the Philippines and Thailand, and they are being scaled up in Bangladesh, India and Sri Lanka.

In the six study countries, information obtained in interviews conducted with key informants indicate that medical care for physical injuries, post-exposure prophylaxis for HIV infection, and emergency contraception are generally available in health facilities. Only Thailand has scaled up the coverage of OSCCs nationwide. In Mongolia, the approach is still only piloted in a few locations with UNFPA support. The other countries are at different stages of developing comprehensive services under the leadership of different authorities such as the Ministry of Social Welfare in Bangladesh, or the Ministry of Labour, Invalid and Social Affairs in Viet Nam.

Papua New Guinea is a country that has captured international attention because of the well-documented high incidence of gender-based violence. In 2005 PNG started a programme of creating Family Support Centres offering medical care, forensic examination, counselling, social support, legal advice, short-term shelter and referral. In 2010, family and sexual violence was included as a strategic area in the national health strategy. [132] A detailed account of the experience of a Family Support Centre supported by Médecins Sans Frontières in Lae, PNG was published in 2016. [133] The centre provided medical care for victims of violence in 6,860 cases over a period of 30 months. During this period, almost five percent of women in the catchment area presented at least once to the centre. About 90 percent required treatment for physical injuries.

In 2013, the chair of PNG's Family and Sexual Violence Action Committee outlined the scale of the situation and the need for support in a speech at the Australian National University.

Right now, we have established Family Support Centres (FSCs) where battered women and children can go for immediate medical treatment and psychosocial support. There are now about 15 of these centres in the country and we have seen around 12,000 women come through them in six years. ... We are getting support to roll out FSCs and [safe houses] across the country, but what is really lacking are our skills to manage cases so that good and proper assistance is given to survivors. We have stories of so many of our women who have been treated at FSCs and kept at safe houses, and then when we send them home they have been murdered. That is because we lack the facilities and skills to manage the cases properly so that proper assistance is given to these women before they are resettled in their communities.

(quoted from: Betteridge A, Lokuge K (2014). *Combating the family and sexual violence epidemic in Papua New Guinea*. Australian National University Development Policy Centre)

EQUITABLE ACCESS TO SRH SERVICES

SOCIAL STATUS

Inequities in access and use of sexual and reproductive health services according to wealth and educational attainment persist in Asia. [134] While more of the poor are reached with basic health services, large equity gaps remain in terms of access and outcomes.

Contraception and fertility

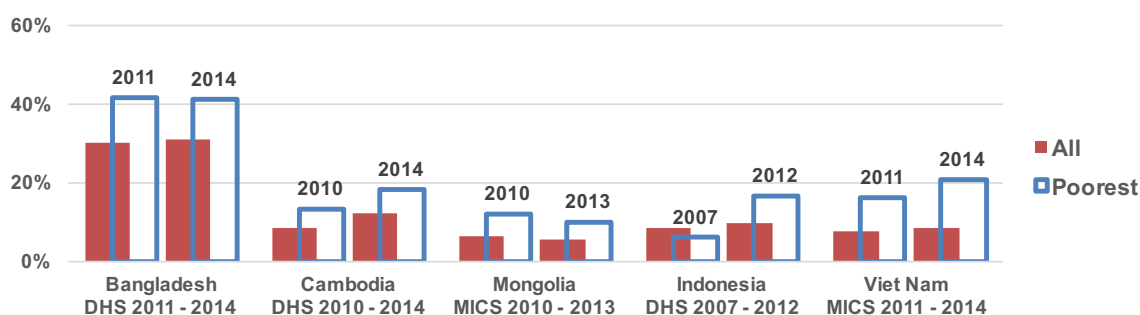
Available trend data for the study countries document that inequities in contraceptive prevalence and satisfied demand have decreased over time. In five of the six countries (all except Indonesia) women in the lowest wealth quintile are today more likely to use modern contraceptives than women in general.

Use of modern contraceptives (married women 15-49)

Use of modern contraceptives (married women 15-49)		
	All women	Poorest wealth quintile
Bangladesh	54.1 %	55.1 %
Cambodia]	38.8 %	39.4 %
Indonesia	57.9 %	53.0 %
Mongolia	48.2 %	57.8 %
Thailand	76.9 %	81.0 %
Viet Nam	57.0 %	61.2 %

Trends and equity gaps in adolescent birth rates, however, show a somewhat different picture. Recent successive population-based estimates of the proportion of girls aged 15 to 19 who have started childbearing are available from five of the six study countries. The overall proportion increased in all countries except in Mongolia, but the gap between the richest and the poorest group did not change significantly in three countries. It increased in Viet Nam, and a major increase was reported by the surveys in Indonesia, which does, however, raise questions of plausibility.

Proportion of adolescents (15-19) who have started childbearing: all adolescents, and adolescents in the poorest wealth quintile

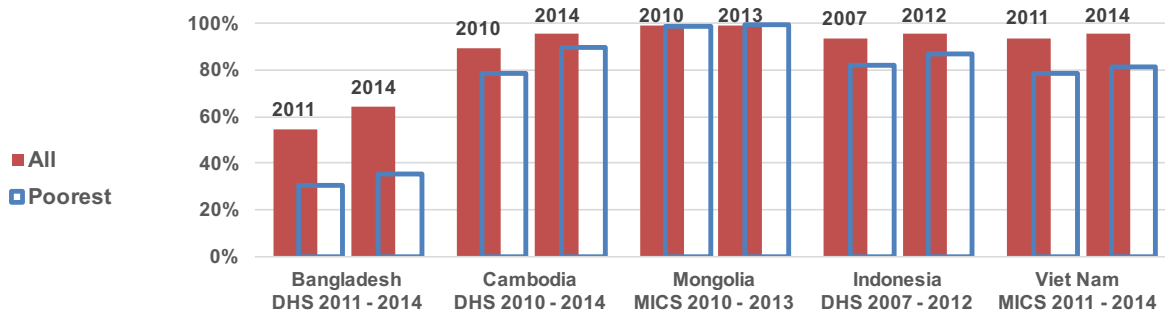


In a regional analysis that aggregated the results of two consecutive population surveys in Asia-Pacific countries, the first conducted between 1998 and 2008, and the second conducted between 2004 and 2014, the adolescent birth rate increased among women in the lowest two wealth quintiles, while it decreased in the three higher quintiles. The gap in the adolescent birth rate between women in the poorest and the richest group increased from about 41/1,000 to 68/1,000. [135]

Maternal health services

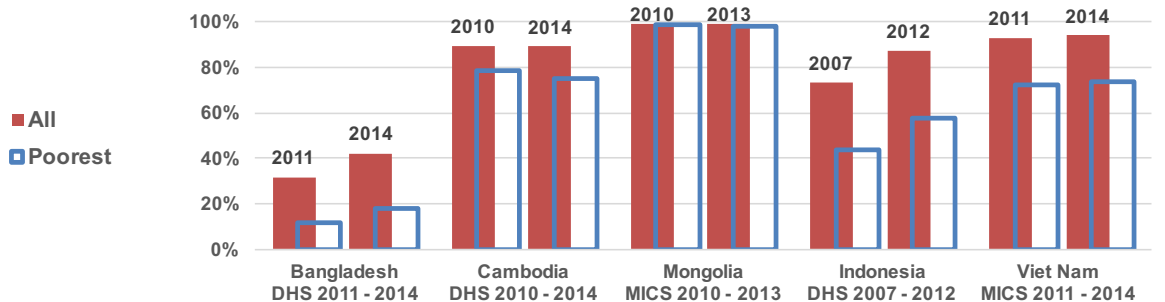
In surveys conducted between 2007 and 2011, the proportion of women who received antenatal care by a skilled provider for their last birth (at least one consultation) was already in the range of 90 percent in the six countries except for Bangladesh. In follow-up surveys between 2013 and 2014, not much change was detected beyond a small increase in coverage. The equity gap of coverage, comparing the coverage of women of the poorest wealth quintile with the total coverage, decreased in Indonesia and Cambodia, while it increased in Bangladesh.

Antenatal care by a skilled provider: all women and women in the poorest wealth quintile



For delivery with the attendance of skilled personnel, the pattern was similar, although the coverage rates were somewhat lower and the equity gaps larger. Between the latest two surveys the equity gap increased in Bangladesh and Cambodia, and it remained virtually unchanged in the other three countries.

Skilled attendance at birth: all women and women in the poorest wealth quintile



In Thailand (not included in the graphic analysis), the latest survey conducted in 2015/16 reported that both the coverage of antenatal care and of skilled birth attendance were almost universal (98.1% and 99.1%). This high level of coverage was already observed in 2005/06, with very minor equity gaps. [70], [72] Data from Thailand and Mongolia confirm that high coverage rates are related to smaller equity gaps. [136]

RESIDENCE

According to a survey conducted by ESCAP and UNFPA on the implementation of ICPD beyond 2014, the main barrier to increasing women's access to comprehensive SRH services in the Asia-Pacific Region was poor access in remote and rural areas. People living in remote rural areas or on remote islands face difficulties in accessing a variety of services because of poor transportation, communication barriers and a tendency of national policies to concentrate service provision in the cities. [137]

When disaggregating the satisfied demand for family planning by residence, large rural/urban differences are seen in Pakistan (17.9%), Nepal (12.2%), Timor-Leste (12.1%) and India (7.6%). Limited availability of and access to a wide range of contraceptive services remains a major challenge throughout the region. Contraceptive stocks in rural and remote areas may be depleted for months at a time.

There are also significant disparities in terms of access and uptake of antenatal care. The greatest disparities are in South and South-West Asia: ranging from a 25 percent difference between women in rural and urban areas in Bangladesh and Pakistan, to a 33 percent difference in Nepal.[137]

In the large countries of the Asia-Pacific Region that extend over many widely dispersed islands, the inequity gaps may not be across the rural/urban divide, but rather between regions with high and low service coverage. In Indonesia, for instance, the 2012 Demographic and Health Survey reported only a small difference in the contraceptive prevalence between rural and urban areas, with higher coverage among rural women (58.7% / 57.0%). The regional contraceptive prevalence rates, however, ranged from 19 percent in Papua to 62 percent in East Java. [44]

Vulnerable groups

Undocumented migrants, internally displaced persons, ethnic minorities, refugees, older persons and persons with disabilities are the groups least frequently targeted by SRH programmes.

Ethnic minorities are among the most vulnerable, disadvantaged and marginalised groups across the Asia-Pacific Region. They are often excluded from decision-making processes, and experience high rates of unemployment as well as low education and health outcomes. [137]

A recent study in Viet Nam explored barriers of access to SRH services among ethnic minorities. Compared to national estimates, antenatal care coverage (at least four consultations) was 58 percentage points lower among respondents from ethnic minority groups than the national average (16% vs 74%). The gap for delivery in a health facility was 53 percentage points (41% vs 94%), and for births attended by skilled personnel it was 45 percentage points (49% vs 94%). [138] Several qualitative studies have tried to explain why ethnic minority groups are disadvantaged in terms of health care in Viet Nam. Among the identified barriers are cultural preference for home deliveries, perceived negative attitudes by health care personnel, language barriers and high transport costs.[139]

Although Viet Nam's poorest populations are covered by social health insurance, co-payments and other indirect costs must be paid out of pocket, which may be a further barrier. The study by the University of Toronto found that 81 percent of ethnic minority women had valid health insurance cards, but only 52 percent used them for ANC services, and 45 percent for delivery at a health facility. Misinterpretation and misunderstanding among community members regarding eligibility for health insurance, and lower coverage among the most disadvantaged families demonstrate an apparent failure of local authorities to communicate the use and benefits of health insurance. [138]

According to ILO estimates, countries in the Asia-Pacific Region host approximately 27.6 million **migrants** over 15 years of age of whom 47 percent are female. An estimated 20.4 million among them are migrant workers, and 2.7 million are migrant domestic workers. Female migrant workers are vulnerable to sexual violence, economic exploitation, physical and verbal abuse and labour rights violations. The flow of undocumented migrants in Asia-Pacific is larger than in all other regions of the world, and it is mainly between neighbouring countries. [140]

The 1990 United Nations Convention on the Protection of the Rights of All Migrant Workers and Members of their Families stipulates that migrant workers are entitled to equal access to social and health services, and have the right to receive any urgent medical services, regardless of their legal status. So far, only Bangladesh, Indonesia, the Philippines, Sri Lanka and Timor-Leste have ratified this convention. [141] In addition, Afghanistan, Bangladesh, China, India, Indonesia, Nepal, Pakistan, the Philippines, Sri Lanka, Thailand, and Viet Nam adopted the 2011 Dhaka Declaration to promote migrant-inclusive health policies ensuring equitable access to health services as well as occupational safety and health. [142]

Migrants face various informal barriers to accessing health services, such as language differences, irregular migration status, lack of information about health and insurance services, the need for permission from the employer to seek health care, employer reluctance to provide health care benefits, and the fact that health facilities might be open only during working hours. [137]

Some health policies discriminate against registered migrant workers. In Malaysia, the policy of mandatory testing requires migrant workers to undergo at least three medical examinations in order to renew their employment permit in the first three years. Those who are HIV positive are deported within three days. A similar policy is also found in Singapore. [143], [144]

Migrants in an irregular situation often find it difficult to access health services because of fear of detection by the authorities. National labour regulations for domestic work also affect the rights of the mostly female migrant workers in domestic employment. Thailand's labour laws, for instance, do not cover domestic workers. [145] In Malaysia, domestic work is not officially recognised as a form of work, and migrant domestic workers are therefore excluded from the Social Security and the Workmen's Compensation schemes. Malaysia also prohibits the entry into the country and the employment of any person who lives or lived off the proceeds of prostitution. Yet sex workers and domestic workers are among the groups of women who are most in need of SRH services. [143]

Little information is available about the access and use of SRH services by migrants. A study among rural-to-urban migrant beer promoters in Cambodia, Laos, Thailand and Viet Nam found that although they were often covered by health insurance, their access to reproductive health services was limited by health care provider stigma, cost, and availability of services, in addition to personal factors such as lack of time and shyness to access services. [146]

A study conducted among local and migrant women in Sabah (Malaysia) found that pregnant migrants started to attend ANC services much later than local women (7 months pregnancy compared to 3 months). Cost was a significant barrier, given their low wages and Malaysia's double-fee policy, which requires foreigners to pay almost double the amount for treatment than Malaysians. Some undocumented migrants prefer to attend private health care despite high costs, as they are not required to present their identification cards. [143]

Conversely, two studies looking at internal migration among garment workers in Cambodia and female internal migration in Myanmar found that access to SRH services among migrant women was relatively high, and higher than among non-migrants. In Cambodia, female garment workers had reasonably high rates of antenatal care and skilled attendance at birth, with most delivering in a public health facility. Knowledge and use of contraception was also consistent with the general population, however, the abortion rate was higher and knowledge about the legality of abortion was low. The study highlighted that garment workers have limited time to access health services, in particular public services. Cost and the distance to health facilities also act as barriers to access SRH services. [147] In Myanmar, female internal migrants were more likely to be of higher socioeconomic status and had better access and use of SRH services than non-migrants. They were 1.6 times more likely to use a modern method of contraception and 1.3 times more likely to use antenatal services and to deliver with a skilled attendant compared to non-migrant women. These findings suggest that social, economic and residence factors may outweigh the effect of migration status among internal migrants. [148]

In 2011, the Asia-Pacific Region hosted 54 percent of the global **refugee** population. Most of the refugees were those who crossed the Afghan border to neighbouring Pakistan and the Islamic Republic of Iran. The region also hosts one of the world's largest populations of internally displaced persons, mainly in Myanmar, Indonesia and India. The right to seek asylum and the right to nationality are verifiably not guaranteed in the majority of the region's countries and territories. There is a significant gap between the right to social protection and the access to services because of legal and administrative barriers. [5]

Very little information is available on the access to SRH services for refugees. A small study of reproductive health issues and quality of life of young people in two refugee camps in Thailand, found that the health services do not target young people. According to the camps' official data, family planning was used by only 12 percent on average, however the pregnancy rate among girls aged 15-19 was 60 per 1,000 and 80 per 1,000 in the two camps. Access to reproductive health information, education and services was limited, and the level of knowledge about sexual and reproductive health and contraception among young people was very low. [149]

FINANCIAL RISK PROTECTION FOR SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The increase of SRH service coverage and the reduction of inequity are two closely related strategic pillars of UHC. The third pillar is the reduction of financial risk. The objective of this pillar is to remove payment at the point of service as a barrier against accessing and receiving needed SRH services. The services, of course, have a cost that cannot be made to disappear. Financial risk protection thereby becomes an issue of health financing.

Health financing is the process of raising revenues, collecting them into a pool of funds to be spent on health services, and using them to purchase the services from providers. In the most inequitable form of health financing, the resources are raised by households when needed, and used to pay for health care at the point of service delivery. Health services in Afghanistan, Bangladesh, Cambodia and India are financed to more than 60 percent in this manner. It is, however, not certain that summary statistics about sources of health financing also apply to sexual and reproductive health services. On the one hand, user fees for maternal health services may have been abolished, on the other hand, family planning services may be excluded from subsidies applied to other health services.

National health accounts studies sometimes also analyse reproductive health sub-accounts. They face a challenge of boundary definition because of overlaps with other sub-accounts such as for HIV and malaria prevention and care. In addition, expenditures on prevention and on services that are not provided by the health sector, for instance for the prevention and response to gender-based violence, are not included. A methodology to define the boundaries of health expenditures has been developed, [150] but the sector boundaries for service provision in sexual and reproductive health are more difficult to draw than for other health services. The main challenge, however, is the fact that reproductive health sub-account studies are expensive and are not done very frequently. An on-line search for recent published reports of reproductive health sub-account studies found only three that were published since 2010: Afghanistan, Tanzania and Malawi. The out-of-pocket contribution to financing reproductive health services in Afghanistan and Tanzania was higher than the general out-of-pocket contribution to total health expenditure, but it was lower in Malawi. The question on whether SRH services are financed to a greater degree by direct payments of households than health services in general, and whether they therefore carry a higher financial risk for individual users, can therefore not be answered with the available evidence.

Out-of-pocket expenditures for health and for reproductive health

	Afghanistan (2011/12)	Tanzania (2010)	Malawi (2011/12)
OOPEX as % of THE	73.3%	31.9%	11.1%
OOPEX for RH as % of THERH	78.5%	47.7%	4.9%

Sources: [151] [152] [153]

UHC strategies direct their focus on developing more equitable mechanisms of pooling funds. While the attention is focused on pooling, the other two functional components of health financing, raising funds and paying providers should not be forgotten. Funds can be allocated from national health budgets, raised from insurance premiums or received as development assistance by international partners. Sufficient funds have to be raised through these channels, or progress towards UHC will be slowed. Equally, SRH services that are not included in the list of benefits to be purchased with the pooled funds have to be purchased directly by the clients as documented in two study countries:

- In Viet Nam, rising costs of health services and decreasing international funding have contributed to a gap in resourcing the pooled funds of the Social Health Insurance. While health insurance is mandatory and coverage rates are high, the proportion of health expenditures that are covered by out-of-pocket payments has not decreased because the tariffs paid to providers from pooled resources do not cover their costs. [154]
- In Mongolia, the government procures reproductive health commodities for vulnerable groups. According to an interview with a nurse at a health centre, free contraceptives are provided to 'vulnerable and high-risk women such as the poor, women with mental disorders and severe chronic diseases'. Meanwhile, sexually active adolescent girls have a rising unmet need for contraception, estimated at 36 percent in 2013. Yet they have to pay for contraceptive commodities. [58]

INCLUSION OF SRH IN FINANCIAL RISK PROTECTION SCHEMES

In all six countries of the study, universal social health insurance is an identified goal of the UHC policy. The aim is to create a single pool of funds from all sources to finance health services: insurance premiums paid by members, general government revenues and international development funds. In Mongolia, this system exists for many years and has reached a high level of national coverage. In Bangladesh, it is only in a pilot phase with a very small population coverage. In Cambodia, it is still in the planning phase, and premiums, tariffs and benefits are still under discussion.

The existing and planned universal social health insurance schemes are not the only system by which States provide financial risk protection for users of sexual and reproductive health services. In some countries in this study social health insurance is the least important system. However, on the assumption that plans to create single unified systems will be pursued in these countries, the current coverage and benefits are presented in the table. The information was not available for the planned social health insurance scheme in Cambodia.

Benefits for selected services covered by the social health insurance scheme

	Bangladesh	Indonesia	Mongolia	Thailand	Viet Nam
Name of SHI scheme	SSK	JKN	SHI	UHC	SHI
Targeted population	95,000 Pilot	258 million Total population	3 million Total population	48 million Sub-population*	94 million Total population
Coverage of target	N/A	66%	>95%	100%	82%
Insured Benefits					
Family Planning	No	Yes	Limited	Yes	No
Emergency contraception	No	No	No	Yes	No
Menstrual regulation	No	No	No	Yes	No
Termination of pregnancy	No	No	No	Yes	Limited
Post-abortion care	Yes	Yes	No	Yes	No
Antenatal care	Yes	Yes	Yes	Yes	Yes
- Laboratory/ Diagnostics	Yes	Yes	Partial	Yes	Yes
- Micronutrients	Yes	No	Yes	Yes	No
- Malaria prevention	No	No	Not applicable	Yes	Not applicable
- PMTCT	No	No	Yes	Yes	Planned for 2017
Obstetric services	Yes	Yes	Yes	Yes	Yes
Post-natal care	Yes	Yes	Yes	Yes	Yes
STI Diagnosis	Yes	Yes	Partial	Yes	Yes
STI Treatment	Yes	Yes	Partial	Yes	Limited
HPV immunisation	No	No	Yes	Yes	No
Cervical cancer screening	No	Yes	Yes	Yes	No
Cervical cancer treatment	Yes	Yes	Yes	Yes	Yes
Services for GBV	No	No	Yes	Yes	No

* The remaining population is insured under parallel schemes with similar benefits for nearly 100% coverage

The fact that some services are not covered as benefits under the national social health insurance scheme does not mean that there is no financial risk protection. In many cases, these services are fully or partially provided without user fees under the public health service delivery system or under a special programme, for instance for malaria or HIV control. This applies, for instance, to family planning services and for malaria control during pregnancy in Bangladesh. Limited or partial coverage means that services are provided under the SHI only to selected populations such as family planning commodities provided only to vulnerable groups in Mongolia; that they are only covered under specific conditions, such as STI treatment in Viet Nam that is only covered if dispensed by a specialised clinic; or that only some of the services in the category are insured, such as the exclusion of 'expensive' diagnostics for antenatal care in Mongolia. The fact that a service is marked in green as being covered by social health insurance, on the other hand, does not necessarily mean that it is widely available. This applies, for instance to cervical cancer screening in several countries.

The status of financial risk protection coverage for sexual and reproductive health in the six study countries can be summarised as follows:

- Maternal health care, including antenatal and postnatal care, is covered everywhere. Policies for the removal of user charges for maternity services were adopted in many countries as part of acceleration plans to reach national Millennium Development Goal targets.
- Treatment services for sexually transmitted infections have a long history of public funding for the purpose of epidemic control. This focus on epidemic control, however, entails that services in some countries are not client-friendly, especially for unmarried adolescents, and push many of them into the private sector where they have to pay for receiving care. Examples among the study countries are Cambodia and Viet Nam.
- There has been a long-standing and very effective international effort to pool funds for HIV care by the Global Fund for AIDS, Tuberculosis and Malaria. Many countries are still depending on this internationally pooled support, but some, for instance Thailand, have completely transferred the costs of HIV care to the national pool of financial resources for health.
- Prevention has a major role in sexual and reproductive health. Prevention objectives include, for instance, the reduction of adolescent births, the elimination of violence against women, and micronutrient supplementation during pregnancy. Many of the activities to address such issues are not fully within the remit of the health sector, and they are therefore not receiving much attention by the emerging UHC schemes. A general neglect of prevention by the social health insurance in Viet Nam, for instance, was mentioned by several key informants interviewed for this study.
- The main health service areas in which there are differences in financial risk protection are those related to fertility regulation: contraception, termination of pregnancy, and post-abortion care. The availability of pooled funds for pregnancy termination and post abortion care is linked to the abortion laws of the country. Less restriction generally means higher probability of financial coverage, although there are exceptions. In Viet Nam, a country with a relatively unrestrictive abortion policy, no services related to termination of pregnancy are included in the UHC schemes. In Bangladesh, a country with restrictive abortion laws, menstrual regulation is not included in the social health insurance scheme, but services are widely available without user charges under the national family planning programme.
- Among the six countries included in this study, the UHC schemes in Thailand and Indonesia provide full cost coverage for contraceptive services, while in Bangladesh publicly funded contraception is provided by the network of primary health facilities operated by the Directorate General for Family Planning. However, 43 percent of family planning users in Bangladesh are procuring their services in the private sector, a proportion that has been rising steadily over the past ten years. In Thailand, the civil servant health insurance plan excludes implants and intra-uterine devices from coverage. In Indonesia, contraceptive counselling, except emergency contraception, is included in the National Health Insurance benefits and commodities are provided by the National Family Planning Board. In Cambodia, the full range of contraceptive services are included in the Ministry of Health service packages, however only the poor are exempted from user fees. In Mongolia, the services are provided free of charge to vulnerable groups only. The Social Health Insurance in Viet Nam does not cover any contraceptive services, but family planning services are provided free of charge to ethnic minority populations by the National Population Programme.

- Differences also exist in the coverage of primary and secondary prevention of cervical cancer, although the main differences are in service coverage rather than in the cost coverage. Nationwide HPV immunisation programmes do not yet exist in any of the six study countries. Although most countries have a national cervical cancer screening programme, only the programme in Thailand reaches a significant coverage with 60 percent of the target, while the next best coverage, in Mongolia, is only at 30 percent. HPV immunisation is only included among the social health insurance benefits in Thailand and Mongolia, and cervical cancer screening only in Thailand, Mongolia and Indonesia. Bangladesh, however, provides the service without user charges when it is available, and user-fee waiver programmes for the poor in Cambodia may also apply to cervical cancer services.

POOLING OF FUNDS FOR UHC

While all six countries included in the study have a declared goal of a universal social health insurance, other financial risk protection schemes exist. They all involve some form of government subsidisation of health insurance funds to cover the poor, vulnerable populations, and workers in the informal sectors. According to a recent study, such initiatives exist in eight low- and middle-income countries in Asia with a total of 14 different subsidisation schemes. [155] The current situation in the six study countries is summarised in the table.

Financial risk protection schemes and per person health expenditures

	Scheme	Start	Targets	% covered	Govt. per person health expend.*	Per person OOP expend.*
Bangladesh	Maternal Vouchers	2010	53 sub-districts (26.5 million)	n/a	9 \$	21\$
	Micro health insurance	variable	n/a	n/a		
	SSK	2016	95,000 (pilot)	n/a		
	Public FP services	1970s	All	n/a		
Cambodia	HEF	2000	Below national poverty line (2.7 million)	≈ 76%	14 \$	45 \$
	User-fee subsidies	2006	n/a	n/a		
	SHI	Just starting	Civil servants and formal sector	n/a		
Indonesia	NHI	2014	Total population (258 million)	≈ 66%	38 \$	47 \$
Mongolia	SHI	1995	Total population (3 million)	> 95%	108 \$	81 \$
Thailand	UCS	2001	≈ 73% of population (48 million)	100%	177 \$	27 \$
	SSS/CSMBS		≈ 24% of population (16 million)	100%		
	MHI	2013	Migrants (3.4 million)	≈ 40%		
Viet Nam	SHI	2008	Total population (93.5 million)	70-80%	77 \$	52 \$

* Source: [6]

The contribution of insurance premiums to the funding pool differs from country to country, with several schemes cross-subsidising health insurance membership across income divides. But collecting premiums other than in the form of payroll deductions is proving to be a challenge as demonstrated by the Viet Nam social health insurance and the migrant health insurance in Thailand. For people who are not in formal employment, the payment of insurance premiums is an important barrier of access to financial protection.

Fragmentation is primarily an issue in Bangladesh and Cambodia. In both countries, health services that are not paid by patients at the point of service are financed by a mix of direct financing from the national health budget, as for instance the family planning services in Bangladesh, and by third-party payment agents with or without government budget support, such as the NGOs operating the health equity funds in Cambodia or the micro-insurance plans in Bangladesh. Attempts to streamline the purchasing function are being undertaken in Cambodia, although these are not as extensive as the on-going initiative in Indonesia to create a single agency to pay for all health services.

Relatively long-established social insurance pooling mechanisms that are financed from a mix of premiums and government transfers exist in Viet Nam and Mongolia. Both are acting in a tight fiscal space and are responding to this situation by limiting the tariffs paid to service providers (in Viet Nam), or by eliminating premium subsidies (for instance for students in Mongolia). The system in Mongolia has not been able to chart any progress in reducing the role of out-of-pocket expenditures in health financing, while the initially encouraging progress in Viet Nam has stalled over the past three years.

Among the six sampled countries, Thailand is the only one that has achieved a level of out-of-pocket financing for health comparable to established industrialised economies through a non-selective system of enrolling all persons who cannot be reached through their payroll in a government-funded insurance pool. Migrants are the only exceptions, and a separate pooling system was established for them which suffers some of the weaknesses of other premium-based systems, i.e. the difficulty of registering and collecting premiums among people who are not fully integrated in the formal economy.

Thailand also has the highest per capita income among the six countries. Government expenditures in health are 13 times higher than in Cambodia and 20 times higher than in Bangladesh. Thailand's choice of using the national budget to finance a universal coverage scheme that does not select by the type of service, nor by the type of beneficiary, has clear equity and efficiency benefits, but it also has a cost. It is difficult to conceive how such a high level of social protection could be achieved in the poorer countries such as Bangladesh and Cambodia.

The relationship between a country's economic wealth and the social protection provided to its citizens, however, is not linear. This applies equally to universal coverage of sexual and reproductive health services. In 2013, the ADB published an assessment of the social protection index in Asia-Pacific in 2009. [156] The numerator of the index is the sum of all public social protection expenditures for social insurance, social assistance and labour market programmes per targeted beneficiary. Social insurance, and especially social health insurance, dominates this expenditure envelope. The denominator is calculated as one quarter of the GDP per capita in local currency. This approximates the national poverty line in most countries of the region and makes the index comparable across countries with different economic core indicators.

Social Protection Index 2009 in six APR countries

	SPI
Mongolia	0.206
Viet Nam	0.137
Thailand	0.119
Indonesia	0.044
Bangladesh	0.043
Cambodia	0.020

Source: [156]

In the index, all public investments in social protection mechanisms, including social health insurance, are aggregated. The data are quite old, dating back to 2009, and predate major national UHC initiatives. Nevertheless, the table indicates the level of government commitment to social spending. It was highest in the countries with socialist political traditions, namely Mongolia and Viet Nam, where government spending on social protection was equivalent to 21 and 14 percent of poverty level incomes respectively. It was lowest in Indonesia, Bangladesh and Cambodia where social insurance mechanisms were underdeveloped, a situation that has since changed, especially in Indonesia.

Economic wealth and political commitment are main drivers for public investment in social protection, but coverage is also determined by the efficiency of the system. This is illustrated by an example from the Republic of Korea. Prior to 2000, three types of health insurance funds existed in Korea with identical benefit schemes and provider payments, but different levels and systems of premium contributions. In 2000, the three funds were merged into a single risk pool. An analysis in 2012 found that the total administrative cost of social health insurance decreased from eight percent in 1996 to less than 2.5 percent in 2008. Meanwhile, the coverage increased from 90 percent of the population in 2000 to 96 percent in 2009. The savings in administrative costs allowed an expansion of benefits, including for instance cancer screening programmes, reduction of co-insurance rates for certain conditions, and the establishment of a cumulative six-monthly ceiling for out-of-pocket expenditures. [157]

While many countries in the region are striving towards the establishment of a national social health insurance system that covers the entire population and provides equitable financial risk protection, the situation of international migrants remains precarious, including in countries that have achieved major progress towards universal health coverage. In Malaysia, for instance, employers are required to provide health insurance to all foreign workers, but many employers do not comply with this regulation. Fully documented migrant workers in Thailand are entitled to be enrolled in the Social Security Fund, as well as in the Workmen's Compensation Fund, which covers work-related injuries and illnesses. Despite this, among the approximately one million documented migrants in 2013, only about one third were enrolled. [5] Documented and undocumented migrants not enrolled in the Social Security Fund have an option to join the Migrant Health Insurance scheme. Membership in this scheme has been increasing, but in 2016 had only reached about one third of the estimated number of migrants in the country. [158]

CONCLUSIONS AND RECOMMENDATIONS

The study sampled six countries in the region and does not claim to be representative. It nevertheless generated a number of findings and recommendations that are relevant for all countries in Asia-Pacific that are committed to achieving the UN Sustainable Development Goals 3.7 (universal access to sexual and reproductive health-care services) and 3.8 (universal health coverage, including financial risk protection). Universal access to SRH services was explored according to an existing framework of comprehensive services [3] with some modifications. Some services listed in the framework, for instance infertility treatment and promotion of breastfeeding were not included, as well as sexual health services for men who have sex with men, transgender and intersex persons. Greater emphasis was placed on a rights-based analysis, and on the acknowledgment of the limits of the health sector contribution to sexual and reproductive health. This arose primarily from an early analysis of data, showing major gaps in adolescent sexual health and in the response to violence against women and girls. The study arrives at seven major conclusions and recommendations that were discussed with the UNFPA Regional and Country Offices, but for which the study team assumes full responsibility. They do not necessarily reflect the views of UNFPA.

1. The health sector focus of UHC is too narrow to capture the SRH agenda

The agenda for sexual and reproductive health and rights extends beyond the health sector. Addressing high levels of adolescent fertility, for instances, requires changes in social norms to promote the rights and equality of girls and to improve the access to information on sexual and reproductive health and rights among adolescents. Preventing and responding to gender-based violence requires the participation of many sectors, including education, justice, social affairs and health. Such multi-sector responses cannot be wrapped up under a single UHC agenda.

Universal health coverage is a health sector goal, a fact that is reinforced by the set of indicators that have been adopted for its monitoring framework. The UHC lens on the availability, quality, accessibility and affordability of health care is useful because it focuses efforts within the sector. But the achievement of sexual and reproductive health goals requires a wider lens. There are many priorities for achieving sexual and reproductive health that cannot be pursued solely as part of a health sector strategy. Health service providers and administrators need to know how to respond to adolescent pregnancy and to gender-based violence, but most of the activities that are necessary to confront these issues are not within their remit and competence. Sexual and reproductive health is not a sub-goal within a UHC strategy, it is a separate strategic domain with a potential for mutual reinforcement. A strategy to promote sexual and reproductive health must also include many policies and programmes that are not within the health sector and that should not be neglected in the pursuit of health sector goals.

Recommendation 1: In defining and setting priorities for sexual and reproductive health at national and international level, governments and development partners should acknowledge and address the overlap and complementarity between UHC and SRH strategies, as well as the areas that are out-of-scope for UHC. Issues of sexual and reproductive health, especially for adolescents and key population groups, should be addressed through actions in the health sector and through actions outside the health sector.

2. Family planning services are excluded from social health insurance schemes

There is a risk that the in pursuing UHC goals, decision-makers at national and international level focus on improving curative health services at the expense of prevention and health promotion. The exclusion of contraceptive services from several national UHC schemes reviewed in this study is a concern, especially as it affects the sexual and reproductive health and rights of adolescent girls.

An obstetric emergency can push a family into poverty if the health services have to be purchased at the point of delivery. If the money is not available, the woman and/or newborn child may die. The need of a 17-year old high school student to obtain an effective contraceptive will not push anybody into immediate poverty. If there is no money to pay for it, it will just be foregone. The consequence may be a pregnancy and illegal abortion, and therefore, in the end, also a pregnancy-related death. While in the first case a very direct relationship can be established between a mechanism that pays for a life-saving service and the life saved, in the second case the relationship is equally strong but less directly and immediately measurable.

National authorities who are monitoring household health expenditures may ask why they should include contraceptive services and commodities among the benefits of social health insurance or other financial risk protection schemes. Purchasing contraceptives will never be a catastrophic health expenditure for an individual or household. However, an unmet contraceptive need because of a foregone expenditure has an impact in the short term on the realisation of sexual and reproductive rights, in the medium term on increasing the probability of an adverse reproductive outcome, and in the longer term on the sustainability of UHC schemes by increasing future costs of covering health care expenditures related to such outcomes.

Recommendation 2: Governments developing social health insurance schemes under the UHC agenda should acknowledge the importance of contraceptive services and act on it by including these services among the insurance benefits. This is especially important for adolescents who generally have a high unmet need for contraceptives, as well as a high rate of unsafe termination of pregnancy. In the longer term, this will not only contribute to meeting commitments to the sexual and reproductive rights of young people, but also to the long-term sustainability of UHC schemes.

3. Insufficient attention is given to prevention and ambulatory services

Emerging social health insurance schemes are not giving sufficient attention to preventive services for sexual and reproductive health such as HPV immunisation, cervical cancer screening and early treatment, micronutrient supplementation during pregnancy, and HIV counselling and testing. Increasing the offer and quality of prevention services and including them among the social insurance benefits will contribute to the realisation of sexual and reproductive health and rights as well as to the sustainability of UHC schemes.

UHC schemes like the social health insurance in Viet Nam or the SSK scheme that is being piloted in Bangladesh, focus very strongly on covering in-patient hospital services. These services are the most likely to generate catastrophic health expenditures, and thereby produce immediately measurable effects on household economies. Meanwhile, prevention services are continuing to be provided under parallel financing arrangements, receiving more or less attention, often depending on the availability of international funding.

As the move towards UHC also includes a move towards defragmentation of health financing systems, there is a risk that the UHC agenda will leave important ambulatory and preventive health services behind. They are, however, important components of a comprehensive sexual and reproductive health strategy. Furthermore, when quality prevention services are widely available and used, future savings on catastrophic health expenditures will be realised, increasing the sustainability of UHC schemes.

Recommendation 3: As a part of a longer-term strategy under the UHC agenda, governments should emphasise preventive services for sexual and reproductive health, such as quality services for cervical cancer prevention, prevention of micronutrient malnutrition among adolescent girls and pregnant women, and prevention of HIV infection. These services should be included among the social health insurance benefits, even if they are currently funded by international partners or special programmes.

4. There is scope to improve the efficiency and sustainability of UHC schemes

A history of international, national and local initiatives has left traces of different types of social protection and health service purchasing arrangements in most countries. Consolidating several initiatives under a single UHC umbrella can create efficiencies that may be invested in the expansion of coverage and level of protection. Schemes that aim at providing comprehensive and universal coverage are less likely to make errors of omission without necessarily generating major additional costs or revenue losses. Comprehensive and universal coverage means providing a broad range of benefits while minimising processes that control or limit access.

Fragmented financial risk pooling systems, social protection initiatives and provider payment arrangements were observed in several countries included in the study, as well as initiatives to gain efficiencies through defragmentation. All six countries in the study have a number of parallel financial risk reduction schemes that predate their commitment to UHC. These include directly government-funded health services, demand-side financing programmes, community-based mutual funds, targeted user fee exemptions, social and commercial health insurance.

Under the commitment to UHC, all six countries have started processes to consolidate these schemes under a single coverage scheme. Consolidation and risk pooling can generate efficiency savings that can then be applied to expanding services and coverage. Despite mandatory health insurance coverage, more than one in five Viet Nameese citizens are uninsured because they cannot afford the insurance premiums or gain access the government subsidy. In contrast, all Thai citizens who are not insured through their place of employment are automatically covered under a fully subsidised universal coverage scheme. Means testing to decide on subsidy levels is avoided, as well as the difficult task of collecting insurance premiums in the informal employment sector. The insurance scheme may forego some premium revenue, but the amount is negligible compared to the gain in efficiency, while 100 percent coverage is assured.

Parallel and sometimes overlapping systems to pay providers of maternity care, family planning, STI control and HIV treatment exist in several countries, creating inefficiencies and distortions. For instance, in some areas of Bangladesh with demand-side financing schemes, excessively high caesarean section rates are recorded. Several social insurance schemes are gradually expanding their range of benefits. Indonesia added family planning services in 2016, Thailand gradually included all HIV prevention and treatment services. The moves towards more comprehensive coverage are likely to create efficiency savings and eliminate distortions.

Recommendation 4: Governments should consider a bold approach to creating universal access to financial risk reduction schemes without complex eligibility requirements, premium structures and tiered subsidies in order to achieve high coverage levels at minimal transaction costs. At the same time, they should consider including all health services that are currently funded through other domestic and international financing mechanisms under a single financial risk reduction scheme, in order to eliminate health systems distortions and avoid potential service gaps.

5. The coverage and financial risk protection for adolescent SRH services needs more attention

In several study countries, there is evidence that the sexual and reproductive health service coverage for adolescents is lagging behind the general trend of improved coverage. This applies especially to unmarried sexually active adolescents. Gaps in availability, quality and acceptability of services are often more important than insufficient financial risk protection. In the development of UHC schemes, the special situation of adolescents should be kept in mind. Adolescents do not necessarily have ready access to the financial resources of the economic group in which they are categorised.

UHC initiatives and policies in the six study countries do not exclude adolescents that otherwise are eligible for subsidised access to services or for insurance premium subsidies. Nevertheless, adolescents in most countries are left behind in terms of access and utilisation of contraception and other SRH services. Many countries have started initiatives to make services more acceptable and accessible to adolescents. It may still be too soon to see results. Yet, consideration should be given to the fact that adolescents may not necessarily have full access to the financial resources of the social and economic group in which they are classified. A young girl in a 'rich' household, whether in the position of wife or daughter, does not necessarily control any financial resources herself. Adolescents therefore need special consideration when subsidy schemes for services or insurance premiums are developed. Mongolia, for instance, abolished its health insurance subsidy for students, a move that seems counterintuitive in view of survey reports that point to significant gaps in the uptake of services by adolescents.

Unmarried adolescents who are sexually active or whose sexual behaviour does not fit cultural or social norms are often excluded from access to SRH services, primarily for reasons related to how the services are being organised or delivered. A survey among young people in Cambodia who were considered to belong to an 'at risk' group, reported that only one third of young women and less than half of young men with symptoms of a sexually transmitted infection sought medical treatment. A study of women with complications following illegal abortions in Thailand reported that one third of them were under the age of 19 years. Unmarried adolescents have a particularly high unmet need for SRH services such as STI treatment, emergency contraception, safe termination of pregnancy and post-abortion care.

Recommendation 5: Governments and development partners should be reminded that providing SRH services for adolescents will, in the long run, have a major impact on national SRH outcomes because they address key issues at a time of highest vulnerability. They should therefore prioritise the service offer and the financing of HPV immunisation, sexuality education and access to contraception, including emergency contraception, that is provided in a way that is acceptable and accessible to adolescents without social and financial barriers.

6. Universal coverage of sexual and reproductive health care is not always universal

The study documented several examples of SRH programmes and financial risk protection schemes that target key populations and vulnerable groups such as ethnic minorities, migrant workers or refugees. These examples, however, document the exception rather than the rule. There are major service coverage gaps that are reflected in health statistics, even in Thailand, the country with the UHC system that has achieved the widest and most comprehensive coverage among the countries in this report. Meeting national targets for sexual and reproductive health will require that equity gaps are narrowed, including the gaps that separate migrants from citizens and ethnic minorities from the majority.

Some countries included in the study have developed and implemented schemes to protect vulnerable populations from financial risks when seeking health care. Thailand offers voluntary Migrant Health Insurance, even to undocumented migrants. Viet Nam provides family planning services without charge to ethnic minority communities. But statistics on service coverage and SRH outcomes collected among such populations continue to show large differences to the national mean throughout the region. Insufficient financial risk protection is usually not the only reason, and also not the main reason. Structural issues of service delivery, culture, language, geography and a distrust of authorities may be more important. A study in Viet Nam reported that less than half of ethnic minority women who were in the possession of a National Health Insurance card actually used it to access maternity services. Addressing inequalities in SRH within countries requires a comprehensive targeted approach to overcome all structural and cultural barriers, and that also includes equitable access to financial risk protection schemes.

Recommendation 6: Governments that are rolling out national UHC schemes should be fully aware of the SRH needs and the barriers to services among groups and communities that have the longest way to travel towards reaching the national SRH goals. Among others, they include the very large populations of ethnic minorities, migrant workers and refugees in the Asia-Pacific region. Closing the equity gap through inclusive and targeted health programming should be a high priority.

7. Gaps in the evidence base constrain informed decision-making for UHC and SRH

Assessments of progress towards UHC in sexual and reproductive health to generate actionable information for decision-makers are constrained in most countries by important information gaps. These include information about service quality, and about reasons why clients do not always take advantage of public services provided free of charge; information about the cost-drivers for out-of-pocket expenditures; information about coverage of migrants and other marginalised populations; and information about the households among whom out-of-pocket expenditures for health constitute a serious financial risk.

The country studies documented that in several countries, public services provided without charge are bypassed in favour of services by private, faith-based or NGO providers that raise direct user charges. Quality and acceptability of services may differ, but more information is required to understand why people are avoiding or bypassing public sector SRH services.

Additional information gaps include the coverage of health services and social protection mechanisms for international migrants and refugees. Furthermore, the metric of 'percent out-of-pocket expenditure of total health expenditure' is a rough measure that does not provide much actionable information. A breakdown of what is purchased (consultations, surgery, laboratory services, medications, etc.) is often available for general health services, but not for SRH. The proposed UHC indicator of 'proportion of households with large household expenditures on health as a share of total household expenditure or income', is more informative. In future, data for this indicator are likely to be collected more frequently and systematically, but they will not provide information about user payments for SRH services.

The study documents that several countries in the Asia-Pacific region are pursuing similar policies and goals in health financing and SRH service provision. Some have embarked on this road many years ago, others have started more recently. A national social health insurance, for instance, exists in Mongolia since 1994, was introduced in Indonesia in 2014, and is currently being piloted in a small area of Bangladesh. In a region that is characterised by increasing regional cooperation in many fields, this provides an opportunity for south-south technical cooperation in order to learn from each other in the development of national health systems.

Recommendation 7: To meet the information needs for decision-making governments partners should consider increasing the evidence-base for UHC and SRH, including:

- Collecting evidence about the effect of out-of-pocket payments for SRH services that are not covered by financial protection schemes because the costs are not considered to be ‘catastrophic’, but that may constitute significant financial barriers for individuals with little access to money, including adolescents, migrants, and the very poor.
- Collecting evidence for reasons why even poor people in some countries bypass public SRH services that are offered free of charge or that are covered by social health insurance, and instead pay for services in the private sector. Research questions should focus on the quality of public services and on barriers of access for specific groups or populations of users.
- Consider to systematically analyse SRH sub-accounts to identify specific cost-drivers, such as consultation, laboratory services or commodities in order to optimise the coverage of financial risk protection schemes.
- Expand regional partnerships and south-south technical cooperation networks in order to maximise the potential of learning from the experience of neighbouring countries.

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