The Partnership for Maternal, Newborn & Child Health

Sida

PRIORITIZING ESSENTIAL PACKAGES OF HEALTH SERVICES IN SIX COUNTRIES IN SUB-SAHARAN AFRICA

IMPLICATIONS AND LESSONS FOR SRHR

This paper was commissioned by the Swedish International Development Cooperation Agency (Sida) and prepared by Jesper Sundewall together with the Clinton Health Access Initiative. This document has been financed by Sida. Sida does not necessarily share the views expressed in this material. Responsibility for its content rests entirely with the author.

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ACKNOWLEDGEMENTS

This document is the result of a collaborative effort. The Swedish International Development Corporation Agency, Sida, funded and coordinated this work which was carried out by Jesper Sundewall, Sida Consultant and Eoghan Brady, the Clinton Health Access Initiative (CHAI) in partnership with the ministries of health of Eswatini, Ethiopia, Malawi, Nigeria, Rwanda, and South Africa.

The publication of this work was coordinated by Miriam Lewis Sabin and Yajna Moloo, under the direction of Helga Fogstad, Partnership for Maternal, Newborn & Child Health. Significant inputs were provided by Veloshnee Govender and Lianne Gonsalves, World Health Organization, Geneva. The document was edited by Joanne McManus and copy edited by Anna Rayne. Phoenix Design Aid produced the design and layout.

FOREWORD

Twenty-five years after the International Conference on Population Development (ICPD) in Cairo, thousands of partners from governments, civil society and multilateral institutions will reconvene in Nairobi in 12-14 November 2019. As we gather, we are confronted by the fact that the world we hoped for in Cairo in 1994 is still a distant reality for too many women, girls and young people. In Nairobi, we will take stock of what has been achieved, but more importantly we will recommit to fulfilling the ICPD promise: achieving zero unmet need for family planning information and services, zero preventable maternal deaths, and zero sexual and gender-based violence and other practices harmful to women and girls.

The cornerstone of "getting to zero" is promoting and protecting sexual and reproductive health and rights (SRHR), for the benefit of all people, for communities and for society generally. However, realizing SRHR for all depends on accelerating the realization of universal health coverage (UHC), delivered by strong primary health-care systems.

UHC has emerged as a key global health priority for achieving Sustainable Development Goal 3: "ensure healthy lives and promote well-being for all at all ages". Momentum is rapidly building at country level. Planning for UHC must be tailored to each country context. A key part of this planning is to determine the health services that will be included in each country's health benefits package. Governments are facing difficult decisions about how to pay for health benefits packages to achieve UHC. At the same time, paying for care should not be a prerequisite for good health. The principle of health as a human right, enshrined in international law, means that essential services should be offered, including for SRHR, regardless of people's ability to pay. An open and inclusive dialogue between governments and civil society – including professional associations and patients' rights groups – about what is, and what is not, included in a nation's health package is essential.

This Sida-commissioned report, developed with technical assistance from the Clinton Health Access Initiative and in collaboration with the respective governments, helps to unpack these complex issues and illustrates the process of SRHR prioritization in health benefits packages in six countries. The case studies on Eswatini, Ethiopia, Malawi, Nigeria, Rwanda and South Africa illustrate the challenges and successes they experienced in that process, including their reforms, revisions and plans. They also reveal the importance of processes for achieving positive outcomes, and the value of multistakeholder dialogues in bringing multiple voices and perspectives to the table.

On the eve of the Nairobi Summit there is strong political commitment to SRHR, as reflected in the most ambitious health declaration ever put before the United Nations General Assembly in September 2019 at the High-Level Meeting on UHC. At this critical juncture, with UHC high on the political agenda, it is our hope that this report will encourage countries, technical experts and civil society to hold frank discussions on how to ensure that essential SRHR services are included in health benefits packages. Indeed, SRHR interventions and services are absolutely essential to achieving UHC and a world in which no one is left behind.

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KEY TERMS

Clinical guideline/Standard treatment guideline: A document intended to guide decisions and criteria regarding diagnosis, management and treatment in specific areas of health care.

Cost-effectiveness analysis: A systematic process to calculate and compare costs and benefits, by key outcomes, of a programme, decision or policy.

Disability-adjusted life year (DALY): A metric used to quantify disease burden. One DALY can be thought of as one year of "healthy" life lost. DALYs combine years of life lost due to population-wide premature mortality with years lost due to disability for individuals living with disease or its consequences.

Essential medicines list: A list of medications considered to be safe and most effective in meeting the priority needs of a health system. The World Health Organization's model list[1] is frequently used by countries developing their local lists of essential medicines.

Financial risk protection: Safeguards to prevent individuals from financial hardship associated with paying for health-care services. Financial risk protection is a key component of universal health coverage.

Essential package of health services: The package of services that a government provides or aspires to provide to all its citizens.

Health technology assessment: The systematic evaluation of the properties, effects and/or impacts of health technology. This multidisciplinary process evaluates the social, economic, organizational and ethical issues of a health intervention or health technology. Its main purpose is to inform policy decision-making.

1 https://www.who.int/medicines/publications/essentialmedicines/en/

INTRODUCTION

Purpose

The Sustainable Development Goals (SDGs) set an ambitious development agenda. For health in particular, countries have been galvanized around the target to "achieve universal health coverage (UHC), 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" (SDG 3.8). "Essential health-care services" include sexual and reproductive health and rights (SRHR), specifically referenced in SDG 3.7: "ensure universal access to sexual and reproductive health-care services". However, ensuring full integration of SRHR in the context of UHC is a complex and multistep process.

Integrating SRHR into UHC means ensuring that people are aware of their rights and entitlements to, and can access, an essential set of SRHR interventions without having to pay more than they can afford. An important first step in integrating SRHR into UHC is to include SRHR interventions in countries' essential health packages (also referred to as health benefits packages).

This document presents case studies from six African countries, and:

- reviews the process by which prioritized SRHR interventions were included in countries' health benefits packages;
- discusses recurring challenges for integrating SRHR interventions in health benefits packages; and
- recommends ways in which common challenges can be overcome.

UHC and prioritization

UHC, providing access to affordable and good-quality health services, is an increasingly major priority around which countries are galvanizing action and resources. It builds on the principles of universality and the right of all individuals to access the health services they need, regardless of their ability to pay and without suffering the risk of financial hardship.

For UHC to be realized, however, the health services offered must be affordable from available funds. Policy-makers must strike a delicate balance, maximizing health outcomes without overlooking the needs of particular populations or persons with specific conditions. The situation is particularly acute in low- and middle-income countries, where public spending on health is rising but remains low overall, and where demand for expanded services is growing rapidly.[2] For example, in these countries the epidemiological transition and the growing burden of noncommunicable diseases (NCDs) create competing demands on the limited resources available: for instance, balancing the costs of improving access to basic reproductive health services for poor women in

2 Glassman A, Gideon U, Smith PC. What's in, what's out: designing benefits for universal health coverage. Washington DC: Center for Global Development, 2017.

rural communities with those of services relating to common NCDs, such as cancer and diabetes, for the urban poor.

There is no single prescribed pathway for countries working to achieve UHC; each nation must decide its own procedure according to its circumstances.[3] However, there are common determinants for success. First and foremost, each country's policy-makers must have a shared vision of UHC. Secondly, each country must develop strategies to mobilize and/or allocate additional funding for health: as the number of people and the services covered increase, so will costs. Thirdly, countries must have a strategy to decrease financial risks and remove barriers to access to health services, particularly for poor and marginalized populations. Finally, countries must develop a plan for promoting efficiency and reducing waste, by identifying and addressing underlying systemic challenges which contribute to poor performance. This includes, for example, ensuring that countries can procure affordable medical commodities and equipment, while also improving the efficiency, quality and overall performance of the health system.

For many countries seeking to implement UHC, an important early step will be to decide which health services will be provided to the entire population. In low- and lower-middle-income countries, these interventions are commonly listed in a "health benefits package", or "essential package of health services". Countries could start by planning to expand coverage for high priority services for the whole population, ensuring that disadvantaged groups are not left behind.[4] While health benefits packages tend to emphasize curative care, it is important to keep in mind that UHC also includes preventive, promotive, palliative and rehabilitative care. For example, prevention and promotion interventions can be more cost-effective than curative services, not only avoiding ill health for individuals but also reducing the burden on health systems.

Why is prioritizing services for inclusion in the benefit package so important, and how should it be achieved? Priorities for selecting services should be based on scientific evidence, ethical arguments and public values. UHC involves the principle of solidarity and its provision requires a human rights-based perspective. A health benefits package must reflect principles such as gender, equity and human rights. The process of service prioritization must also be transparent and inclusive, not only for that process to be viewed as legitimate by civil society and the general population, but also to improve outcomes. Furthermore, the use of transparent criteria for assessing services enables policy-makers to justify priority decisions while allowing open debate about the objectives of the health system.

All countries have finite resources. Consequently, each must decide which health services to provide. However, in sub-Saharan Africa, despite major health gains over the past two decades, only about one third (approximately US$ 5 per capita) of annual government spending on health goes to the most cost-effective health interventions.[5] Large health gains can be achieved by reallocating funds from existing budgets to the most cost-effective interventions. For example, the Lancet Commission on Investing in Health argues that by increasing health investments several low-income countries could reduce rates of infectious, child and maternal deaths to the levels achieved by the best-performing middle-income

3 Kutzin J, Witter S, Jowett M, Bayarsaikhan D. Developing a national health financing strategy: a reference guide. Health Financing Guidance Series No 3. Geneva: WHO, 2017.

4 Making fair choices on the road to universal health coverage. Geneva: WHO, 2014.

5 Public financing for health in Africa: from Abuja to the SDGs. Geneva: WHO, 2016.

countries, thus achieving a "grand convergence" in health by 2035.[6] In other words, large health improvements can be achieved by more efficient use of existing resources.

The case for SRHR in UHC

The movement towards UHC creates a unique opportunity to advance the SRHR agenda, offering a window through which to improve access to essential SRHR interventions. It is well established that most SRHR interventions are cost-effective, cost-saving and inexpensive. This is true of curative as well as promotive and preventive interventions. Contraception, maternal care and HIV prevention interventions, for example, can all achieve tremendous health gains at relatively little cost. The recent Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights estimated the annual cost of an essential set of SRHR interventions to be approximately US$ 9 per capita in developing regions,[7] and therefore affordable even for countries with very limited public health spending. Although laws, policies, and cultural and social norms still drive resistance to some aspects of SRHR (notably abortion services and autonomous access to SRHR care by adolescents) evidence shows that prioritizing SRHR care in resource-constrained settings both enhances health and promotes health equity. The Commission's report also indicated that if these services were prioritized through an open and transparent process, using gender- and equity-adjusted cost-effectiveness models based on the best available evidence, SRHR interventions would naturally be included in health benefits packages. In reality, this is not always the case.

The case studies' focus on each country's development of a health benefits package has both strengths and limitations. It allows detailed consideration of one way in which stakeholders can influence the choice of SRHR interventions to be subsidized and delivered at country level, and proposes specific processes for engagement. However, in most countries, decisions about SRHR care provision involve multiple ministries and government agencies, and focusing only on actions by the ministry of health does not reflect that collaborative multisectoral effort. For example, comprehensive sexuality education may be the responsibility of the ministry of education, while preventing gender-based violence may be addressed by the justice system. Many services are also available in the private sector where patients have to pay additional user fees. A more comprehensive mapping of SRHR interventions must therefore include activities beyond the health benefits package and the health sector.

6 Jamison D, Summers L, Alleyne G et al. Global health 2035: a world converging within a generation. Lancet 2013; 382 (9908):1898–1955.

7 Starrs A, Ezeh A, Baker G et al. Accelerate progress–sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. Lancet 2018; 391(10140):2642–2692.

CASE STUDY DEVELOPEMENT: DOCUMENTING SRHR IN UHC

At the core of this document, and informing the key lessons learned, are six country case studies documenting the nationally-led development of health benefits packages for Eswatini (formerly Swaziland) Ethiopia, Malawi, Nigeria, Rwanda and South Africa. These countries were selected to reflect a variety of approaches to, and procedural steps towards, developing and integrating SRHR into their benefits packages.

In its 2018 report, the Guttmacher-Lancet Commission presented an evidence-based definition of SRHR accompanied by a summarized and costed list of recommended interventions to be implemented by countries. This list[8] of nine essential intervention areas (see Box 1) serves as model for essential SRHR services to which country health benefit packages were compared.

Development of the six country case studies began with a desk review of benefits package documentation, in which the services offered in each country's health benefits package were compared with and mapped onto the Guttmacher-Lancet Commission's recommended interventions. As benefits packages are specified in varying levels of detail, this was a high-level grouping of services. The benefits packages do not specify interventions categorized as "not Included". Where there was no clear 1-1 match, interventions were mapped to the closest SRHR intervention area. Services falling outside SRHR were excluded.

Following this mapping, country teams were formed, comprising government partners from ministries of health, national insurance agencies and country offices of the Clinton Health Access Initiative (CHAI) (which was involved in developing the respective benefits packages and prioritization processes). Each team reported their country's SRHR and UHC context: how the process unfolded, the motivation and objectives in including SRHR services in the health benefits package, and some of the key stakeholders involved, as well as specific approaches for ensuring participation. To supplement these narratives, supporting documents such as health sector strategic

8 Starrs A, Ezeh A, Baker G et al. Accelerate progress–sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. Lancet 2018; 391(10140):2642–2692.

plans, health financing strategies and national programme documents were reviewed to explore targets, reforms and challenges in the health system, and the progress of UHC reform in each country.

Country teams were also consulted on the results of the SRHR mapping exercise, and provided descriptive background, for example on why some intervention areas were better represented than others. Senior government officials were provided with a draft of their case study for editing and comment. Based on the case studies a set of overarching lessons learned and recommendations for SRHR stakeholders was developed.

A specific approach was adopted in developing the case studies, but it is emphasized that these case studies are illustrative only. Although they are based on insiders' perspectives, other actors, meetings and politics may have been left out of account.

BOX 1.

Guttmacher-Lancet Commission's essential package of sexual and reproductive health interventions

- Comprehensive sexuality education
- Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods
- Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care
- Safe abortion services and treatment of complications of unsafe abortion
- Prevention and treatment of HIV and other sexually transmitted infections
- Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence
- Prevention, detection and management of reproductive cancers, especially cervical cancer
- Information, counselling and services for subfertility and infertility
- Information, counselling and services for sexual health and well-being

CASE STUDY

ESWATINI

Eswatini is a lower-middle-income country and spends 14.9% of its budget on health (2015). With one of the better resourced health sectors in the region, Eswatini has not been forced to make as many explicit trade-offs for basic services as its neighbours, and has a broad benefits package in the public sector, with most services provided free of charge. This extends to complex curative interventions and tertiary care, made available by referral to the domestic and South African private sectors, through a national funding source outside the Ministry of Health called the Phalala Fund. The burden of HIV/AIDS has led to a development partner concentration on this area, and strong vertical systems relating to drugs, personnel, laboratory tests and other health technologies. It is now experiencing development partner transition on an accelerated timeline, while its economy is contracting, threatening health gains already made. Skilled personnel attend 88.3% of births, and 76.1% of pregnant women received at least four antenatal care visits. Maternal mortality remains high at 389 (2015) and the under-5 mortality rate was 53.9 per 1,000 live births.[9] See Table 1 for key demographic and health indicators.[10]

Prioritizing the benefits package: Eswatini developed its Essential Health Care Package in 2012. The aim is to define the services to be delivered across all levels of the public health sector, rather than to prioritize resource allocation. It is a "positive" health benefits package, in that it does not explicitly exclude any services. Debates over inclusion centred on the level at which services should be delivered, rather than whether they should be included at all. The first revision of the package began in 2015 and was completed in 2017. This used data from the 2014 Service Availability Mapping to identify gaps in the delivery of the benefits package; however, intervention areas are described in very general terms so it is difficult to assess the specific interventions to be delivered. These are set out in Clinical Practice Guidelines and the Essential Medicines List. Service areas prioritized in the first revision of the Essential Health Care Package are summarized and compared with the SRHR interventions recommended by the Guttmacher-Lancet Commission in Table 2 below. Some intervention areas are so generally described that much ambiguity surrounds what will be implemented and how, for example in "Sexually transmitted infections" and "Adolescent reproductive health". It is unclear whether these include preventive or curative interventions, or areas such as sexual health education, gender-based violence, safe abortion and information and counselling: none of these recommendations by the Commission is explicitly cited here. Interestingly, a relatively wide scope of interventions concerning cervical cancer are included (discussed below).

Participation: The initial development of the health care package was government-led but formed part of a World Bank-funded project. The newly created office of Essential Health Care Package coordinator

9 All numbers from WHO Global Health Observatory, most recent year available.

10 General Disclaimer. Indicator estimates in this case study may differ from those listed on the WHO Global Health Observatory or other UN estimates' websites.

in the Ministry of Health is entirely funded by the Bank. The development of the package was informed by consultations with Ministry of Health departments, including a workshop with clinical advisors (health personnel, private and public hospitals) and development partners. Most sexual, reproductive, maternal, newborn and child health interventions were broadly captured under "Family Health". While data on disease burden and service availability were relied on, this is only apparent in the provisions concerning cervical cancer. As evidence of Eswatini's high burden of breast and cervical cancer emerged from the data, a local civil society organization, the Swazi Breast and Cervical Cancer Network, began to engage actively with various agencies across the Ministry of Health. Their strong advocacy was influential, due to their effective mobilization of evidence and their coordinated and continuing engagement with multiple government decision-makers, and they were invited to participate in the benefits package revision workshop, resulting in several more specific interventions being captured.

Table 1. Eswatini: key demographic and health indicators

Total population (2016)[1]	1,343,000
GNI per capita (PPP international US$, 2013)[1]	6,220
Life expectancy at birth M/F (years, 2016)[1]	55/60
Total expenditure on health as % of GDP (2014)[1]	9.2
Out-of-pocket expenditure as % of current health expenditure (2016)[2]	10
Voluntary health insurance as % of current health expenditure (2016)[2]	4
Nurses & midwives / 10,000 pop. (2015)[3]	20.000
Physicians / 10,000 pop. (2016)[4]	0.796
Percentage of births attended by skilled health personnel (2012-2014)[5]	88.3
Percentage of married or in-union women of reproductive age whose need for family planning was satisfied with modern methods (2014)[5]	80.6
Abortion at the woman's request (Y/N)[6]	N

[1] WHO Global Health Observatory https://www.who.int/gho/en/
[2] Global Health Expenditure Database http://apps.who.int/nha/database/Select/Indicators/en
[3] African Statistical Yearbook 2018 https://www.un-ilibrary.org/economic-and-social-development/african-statistical-yearbook-2018_197757d1-en-fr
[4] Demographic and Health Survey 2016 https://microdata.worldbank.org/index.php/catalog/2886
[5] 2017 Performance Monitoring and Accountability 2020, Round 5 https://www.pma2020.org/pma2017-ethiopia-round-5-soi-table-en
[6] Global Abortion Policies Database https://abortion-policies.srhr.org/country/ethiopia/

Challenges: Eswatini's Essential Health Care Package is not prescriptive, and is not used to include or exclude services at health facilities, although descriptions of what can be delivered at each level of care, combined with clinical guidelines and the essential medicines list, effectively ration some services. There are political barriers to excluding services. The King created the Phalala Fund to provide tertiary care to all citizens, either in Eswatini or abroad if no service is available here. An important challenge to the financing of UHC in Eswatini is its reliance on revenue from the South Africa Customs Union, which has been decreasing in recent years. This has led to a contraction of the overall budget, with a ceiling being placed on the health budget for 2018.

Development partner transition is another challenge. The high burden of HIV/AIDS has led to strong vertical programmes, primarily funded by development partners, especially the US Government. As a middle-income country, Eswatini is ineligible for many categories of development partner funding, including GAVI. In the past, procurement through multiple private suppliers resulted in vaccine shortages and delays. Transition planning for HIV programmes is underway in the Ministry of Health, with much uncertainty about how current processes of procurement and service delivery can be maintained.

Successes: Assessments were conducted in hospitals and health centres across Eswatini to identify shortfalls in the drugs, equipment, laboratory services and personnel necessary to deliver the Essential Health Care Package. This data enabled facilities to budget for making good those gaps in General Service Readiness: the basic requirements for sufficient equipment, supplies and personnel to provide baseline standardized services across the country. Further assessments are planned for 2019 to measure gaps in the delivery of treatment for noncommunicable diseases and some maternal, newborn and child health services, as a step towards implementing these elements of the benefits package. The way in which treatment for cervical cancer was built into Essential Health Care Package has had a real effect on national policies, and illustrates how SRHR actors can affect the UHC agenda by engaging with the prioritization process.

Reforms, revisions and plans for the future: Eswatini has an inefficient system of managing health facilities: a tripartite team of head clinician, head nurse and head administrator manages each hospital and regional health office. The Ministry of Health is planning to reform this system by introducing a Chief Executive Officer and board, more financial autonomy for facilities and better payment incentives for health workers. A package of noncommunicable disease interventions is being implemented nationally to screen for hypertension and diabetes, to counter the high burden of disease in Eswatini, with task shifting to community level for basic interventions. There is also a proposal (based on a recent World Bank consultancy) to establish an agency to purchase health services from the public and private sectors and to improve data systems to make this process more strategic. One option being considered is to finance this through a tax-based national insurance system. The government is planning to perform a re-prioritization exercise for

another benefits package revision and has recently begun costing work on a subset of interventions. This presents an opportunity for SRHR advocates to engage with key government officials and partners involved in the re-prioritization and provide evidence for SRHR interventions to be specified in detail in the package, following the example of advocacy for cervical cancer treatment.

Table 2. Interventions recommended by the Guttmacher-Lancet Commission on SRHR and their inclusion in/omission from Eswatini's health benefits package

Interventions recommended by the Guttmacher-Lancet Commission	Eswatini Essential Health Care Package - interventions included/omitted
Comprehensive sexuality education*	• Not included
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Family planning • Adolescent reproductive health
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Antenatal care/postnatal care • Delivery and newborn care
Safe abortion services and treatment of complications of unsafe abortion	• Not included
Prevention and treatment of HIV and other sexually transmitted infections	• Prevention of mother-to-child transmission of HIV • HIV testing and screening • Antiretroviral therapy initiation • Refills • Sexually transmitted infections
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence	• Not included
Prevention, detection and management of reproductive cancers, especially cervical cancer	• Screening (palpation) • Pap smear/visual inspection with acetic acid • Cryotherapy • Cervical cytology
Information, counselling and services for subfertility and infertility	• Not included
Information, counselling and services for sexual health and well-being	• Not included

* Comprehensive sexuality education is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.

CASE STUDY

ETHIOPIA

With relatively limited health spending (US$ 29 per capita annually), Ethiopia has significantly improved its health outcomes.[11] This is largely due to the government's prioritization of primary health care for the entire population, as a step towards the goal of universal health coverage.[12] However, Ethiopia still faces challenges. While the country saw a 70% decline in maternal mortality between 1990 and 2014, the maternal mortality ratio remains at 353 per 100,000 live births. The under-5 mortality rate is 58.5 per 1,000 live births. A skilled attendant is present at 28% of births. Only 32% of pregnant women receive four antenatal visits.[13] See Table 3 for key demographic and health indicators.

Moreover, this limited health spending currently relies heavily on development partner funds and out-of-pocket expenditure (36% and 33% of total health spending, respectively).[14] An estimated 6% of government spending is on health.[15] Patients incur fees for essential services, specifically for supplies, labs and medications such as antibiotics for common infections. In a household survey, 40% percent of people interviewed stated that the cost of care prevents them from seeking services, contributing to low health care utilization (0.6 visits per capita).[16] Efforts to address the benefits package, and in turn the cost-sharing arrangement between individuals and the government, should produce important improvements in health care access, and ultimately in health outcomes.[17]

Prioritizing the benefits package: Ethiopia's 2005 Essential Health Service Package (EHSP) outlines three tiers of services: (i) exempt services, which are free for the entire population; (ii) an essential or

11 National Health Accounts VI. Government of Ethiopia, 2017.

12 Visioning Ethiopia's path towards universal health coverage through primary health care. Government of Ethiopia, 2014.

13 All numbers from WHO Global Health Observatory, most recent year available.

14 National Health Accounts VI, Government of Ethiopia, 2017.

15 WHO global health expenditure database 2016.

16 Ibid.

17 General Disclaimer. Indicator estimates in this case study may differ from those listed on the WHO Global Health Observatory or other UN estimates' websites.

minimum package of services, for which patients share costs with the government by paying user fees; and (iii) services outside of this package (e.g. more expensive tertiary services) for which patients pay. In addition, a fee waiver exempts the indigent population from user fees for any essential or referred services. The rationale for the EHSP was that, while some health issues (e.g. HIV/AIDS) were well understood and funded, no comprehensive health-care package was in place. This package prioritizes most of the interventions recommended by the Guttmacher-Lancet Commission on SRHR (see Table 4). However, its terms are less explicit about the key areas of prevention and promotion: for example, gender-based violence and cervical cancer are not included (although these issues are now expected to be revisited). The package also includes key services at community and primary care levels, as well as some prevention and promotion services provided through health extension workers.

The EHSP is intended to provide for core health and health-related services that are promotive, preventive, curative and rehabilitative and can be delivered at community or primary care level. An appointed task force (see 'Participation') began by identifying core health interventions to address the country's major health problems and disease conditions. These were considered to be essential interventions that people could expect to receive near their homes. Because the package was larger than the available budget, prioritization was required. Stakeholders discussed and considered evidence on necessity ("services that when missed will have a disastrous and intolerable outcome, as in the case of exposure to rabies"), cost-effectiveness, affordability and capacity in terms of human resources to deliver the service, and equity. The existing packages of services for Ministry programmes, including existing plans and guidelines, were a strong consideration.[18]

Participation: The Federal Ministry of Health developed the EHSP in 2005 with support from WHO and USAID, through a task force including various departments at federal and regional

18 EHSP. Government of Ethiopia, 2015.

levels. Regional governments are able to make amendments to this core package and the cost-sharing arrangements once this was defined, according to resource availability. The EHSP was enforced through quality assurance programmes that monitor its implementation and the health sector generally.

Challenges: Regional and district (*woreda*) health offices have full autonomy over their budgets, leading to variation in the funding and delivery of the package. Limited detail is included about fee structures for essential health services, including how fees will be updated and communicated.

Successes: The first EHSP helped health facilities by clearly stating which health interventions and services should be made available to the entire population. It also helped set comprehensive service delivery standards at each level of care, and was used to raise funds from development partners to expand primary health coverage, including for system strengthening, as part of a health sector development programme. The Government

Table 3. Ethiopia: key demographic and health indicators

Total population (2016)[1]	102,403,000
GNI per capita (PPP international US$, 2013)[1]	1,350
Life expectancy at birth M/F (years, 2016)[1]	64/67
Total expenditure on health as % of GDP (2014)[1]	4.9
Out-of-pocket expenditure as % of current health expenditure (2016)[2]	37
Voluntary health insurance as % of current health expenditure (2016)[2]	1
Nurses & midwives / 10,000 pop. (2017)[3]	8.4
Physicians / 10,000 pop. (2017)[3]	1.000
Percentage of births attended by skilled health personnel (2011-2016)[4]	27.7
Percentage of married or in-union women of reproductive age whose need for family planning was satisfied with modern methods (2014)[5]	59.4
Abortion at the woman's request (Y/N)[6]	

[1] WHO Global Health Observatory https://www.who.int/gho/en/
[2] Global Health Expenditure Database http://apps.who.int/nha/database/Select/Indicators/en
[3] African Statistical Yearbook 2018 https://www.un-ilibrary.org/economic-and-social-development/african-statistical-yearbook-2018_197757d1-en-fr
[4] Demographic and Health Survey 2016 https://microdata.worldbank.org/index.php/catalog/2886
[5] 2017 Performance Monitoring and Accountability 2020, Round 5 https://www.pma2020.org/pma2017-ethiopia-round-5-soi-table-en
[6] Global Abortion Policies Database https://abortion-policies.srhr.org/country/ethiopia/

of Ethiopia played a strong leadership role in advocating with development partners to jointly fund this EHSP. The resulting joint fund was used to pool and allocate development partners' funding for these essential services and system strengthening needs. This was enabled by the framework of the Ethiopia International Health Partnership compact. The success of the pooled fund was due to a robust costed plan for operationalizing the essential service package, as well as a resource mapping exercise to track how funding is used, within the terms of the plan, to identify gaps and to reprogramme resources. Finally, exempt services, often paid for through the pooled fund, are communicated to the public through signage outside facilities that can be easily read by patients, enabling them to hold providers accountable for free care.

Reforms, revisions and plans for the future: The Government of Ethiopia's new Health Care Financing Strategy aims to address resource constraints and out-of-pocket spending by changing the way in which funds are raised, redistributed and spent through a broader health financing reform. This includes a community-based health insurance scheme at the district level, which has been launched in 374 districts, and a social health insurance scheme that has not yet been launched.

Currently, almost all services available in the public sector are included in the community-based health insurance benefits package, which explicitly includes all services except those specifically excluded (such as eyeglasses and tooth implants). The revised scheme replaced fee waivers were with premium waivers. Having reviewed the initial evidence from these schemes, the Government will consider whether and how to adjust the benefits package to include greater specification of the services included.

In parallel, the Ministry of Health, together with key stakeholders, plans to revise the 2005 EHSP in 2019. This will influence the insurance benefits package (which includes services provided at public facilities). However, it is not yet clear whether it will include a more explicit link to insurance. The revised list is intended to include all cost-effective and high-impact interventions that are already available, as well as listing additional interventions prioritized according to the following criteria: cost-effectiveness, equity, impact and financial risk protection, particularly for the poor, based on the WHO principle of "making fair choices".[19] Additional criteria, such as the severity of the health problem, urgency and public and political concerns, will be taken into account through consultation, public hearing and discussions with stakeholders. This list will also reflect an increased focus on the continuum of care.

SRHR actors can play an important role by generating evidence to show what is needed to deliver this package of services (e.g. systems strengthening). They may find entry points to influence resource allocation and user fee revision

19 The methodology was based on: Making fair choices. WHO, 2014. https://www.who.int/choice/documents/making_fair_choices/en/

at regional and local levels. In addition, there will be opportunities to inform the process of updating this package, and the services covered by insurance over time. For example, as there are changes in resource availability (e.g. development partner transition) and service availability (e.g. the introduction of cancer services).

Table 4. Interventions recommended by the Guttmacher-Lancet Commission on SRHR and their inclusion in/omission from Ethiopia's health benefits package

Interventions recommended by the Guttmacher-Lancet Commission	Ethiopia Essential Health Care Package - interventions included/omitted
Comprehensive sexuality education*	• Not included
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Health posts: counselling and provision of condoms, mini pills, combined pills and injectables • Health centres: provision of long-term contraceptives, including Norplant, IUD • District hospitals: provision of all forms of family planning, including permanent methods; treatment of abnormal menstruation including D&C • Community-level activities include family planning information and services and activities during pregnancy and breastfeeding
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Health posts: antenatal care and follow-up of pregnant women, provision of supplements, and information/education/communication • Health centres: comprehensive antenatal care, screening and management of pregnancy conditions, management of complications in neonates • District hospitals: skilled intervention for high-risk mothers, including in-patient and maternity waiting area
Safe abortion services and treatment of complications of unsafe abortion	• Health centres: management of abortion, including manual vacuum aspiration • District hospitals: management of complications
Prevention and treatment of HIV and other sexually transmitted infections	• Health posts: information, education, communication and counselling on HIV/AIDS, support and guidance on home-based care, voluntary counselling and testing (VCT) • Health centres: screening for and counselling on STIs/HIV/AIDS; prevention of mother-to-child transmission of HIV (PMTCT); treatment of AIDS and opportunistic infections (OIs) • District hospitals: VCT; diagnosis and antiretroviral treatment; treatment of OIs; PMTCT
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence	• Not included
Prevention, detection and management of reproductive cancers, especially cervical cancer	• Not included
Information, counselling and services for subfertility and infertility	• Not included
Information, counselling and services for sexual health and well-being	• Health posts provide information, education, communication and counselling on sexuality and related issues, including HIV/AIDS and HIV testing and prevention

* Comprehensive sexuality education is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.

CASE STUDY

MALAWI

All essential health care services in Malawi's public sector are in theory free at the point of delivery; however, the services offered are severely limited by the lack of available resources, with facilities making services available in an ad hoc manner. Efforts to prioritize, although supported at the policy level, have been hampered by the health system's lack of capacity to deliver even prioritized services, and by resource limitations at all levels of implementation, insufficient communication of policies to health workers, and duplicative parallel systems due to reliance on development partner funding. Government spending makes up 25.5% of total health expenditure, with development partners contributing on average 61.6% between the financial years 2012/13 and 2014/15. Of Malawi's public budget, 10.4% is spent on health.[20] Ninety-one percent of births are attended by a skilled attendant. The proportion of pregnant women aged 15-49 receiving antenatal care from a skilled provider is 95%, while only 51% of pregnant women receive four or more antenatal visits. Maternal mortality is high at 439 per 100,000 live births. Under-5 mortality has fallen considerably in recent years but was still at 63 per 1,000 live births in 2016.[21] See Table 5 for key demographic and health indicators.[22]

Prioritizing the benefits package: Malawi Essential Health Package is currently in its fourth version. The latest package, for the period 2017-2022, is prioritized principally according to health maximization. Under this criterion, interventions were deemed cost-effective if their incremental cost-effectiveness ratio was below Malawi's cost-effectiveness threshold of US$ 61 per disability-adjusted life year (DALY) averted. After considering cost-effectiveness, burden of disease was calculated for each intervention. Interventions were then ranked according to their impact on total population health (assuming expected case numbers) measured in DALYs averted. Other criteria included equity, continuum of care and complementarity of services. The package was validated and approved through a deliberative process. The estimated cost of drugs and commodities in the package is US$ 194 million per annum for the period 2017/18-2021/22. Programme management costs are US$ 108 million per annum, equivalent to approximately 58% of the estimated total strategic plan cost per annum and 71% of total health expenditures recorded in 2014/15.[23] This is high considering that the government contributes only 25% of total health expenditures; however, previous iterations of the package had much higher associated cost estimates, rising to approximately 134% of total health expenditure in 2015.

SRHR interventions were included in the prioritized package under the RMNCH category, as documented in Table 6 below. Of the interventions recommended by the Guttmacher-Lancet

20 Ministry of Health, 2016. Malawi National Heath Accounts Report for Fiscal Years 2012/13, 2013/14 and 2014/15. Ministry of Health, Department of Planning and Policy Development.

21 National Statistical Office of Malawi. Malawi Demographic and Health Survey 2015-2016 report.

22 General Disclaimer. Indicator estimates in this case study may differ from those listed on the WHO Global Health Observatory or other UN estimates' websites.

23 Malawi National Health Accounts. 2015 report.

Commission on SRHR, none were included relating to comprehensive sexuality education, sexual and gender-based violence, infertility, or information, counselling and services for sexual health and well-being. Treatment of complications from unsafe abortion was also not included, although post-abortion case management was. The cost of implementing the full package of RMNCH interventions was estimated at US$ 34 million annually, compared with an estimated US$ 12 million for RMNCH in 2017-18.[24] According to the most recent resource mapping in the year 2017/2018, funding from development partners amounted to 99% of all resources for RMNCH. (This number excludes commodities because no data on these were available from Central Medical Stores Trust; however, other data indicate that development partners contributed a similar proportion of the cost of commodities.

Table 5. Malawi: key demographic and health indicators

Total population (2016)[1]	18,092,000
GNI per capita (PPP international US$, 2013)[1]	750
Life expectancy at birth M/F (years, 2016)[1]	61/67
Total expenditure on health as % of GDP (2014)[1]	11.4
Out-of-pocket expenditure as % of current health expenditure (2016)[2]	11
Voluntary health insurance as % of current health expenditure (2016)[2]	3
Nurses & midwives/10,000 pop.(2016)[3]	2.528
Physicians/10,000 pop. (2016)[3]	0.157
Percentage of births attended by skilled health personnel (2015-2016)[4]	89.8
Percentage of married or in-union women of reproductive age whose need for family planning was satisfied with modern methods (2016)[4]	74.6
Abortion at the woman's request (Y/N)[5]	Not specified

[1] WHO Global Health Observatory https://www.who.int/gho/en/
[2] Global Health Expenditure Database http://apps.who.int/nha/database/Select/Indicators/en
[3] Ministry of Health, HRH Assessment Report 2016 accessed via WHO Global Health Observatory https://www.who.int/gho/en/
[4] Demographic and Health Survey 2015-2016 https://microdata.worldbank.org/index.php/catalog/2792
[5] Global Abortion Policies Database https://abortion-policies.srhr.org/country/malawi/

24 Authors calculation based on resource mapping: http://www.health.gov.mw/index.php/reports?download=54:resource-mapping-round-5

Participation and process: The process was government-led; the Centre for Health Economics at the University of York in the UK provided the framework for prioritization. An economic evaluation was undertaken to rank interventions, followed by a consultative process to take into account a wider set of political, ethical and health system considerations. During the first stage, a threshold was set for cost-effectiveness of interventions, in terms of cost per DALY averted. The interventions were then ranked according to their effect on population health, taking into account, as far as possible, the characteristics and limitations of the existing health system, including their overall effect on the health budget. During the second stage a series of consultations was held with stakeholders to take account of existing services and cultural expectations, continuum of care and complementarity of interventions, health system limitations and equity considerations. Considerations such as equity were considered with reference to expert opinions, rather than equity-adjusted quantitative methods, so it is difficult to assess how gender, socioeconomic and geospatial inequities were accounted for: this may be particularly salient for SRHR.

Challenges: Much of Malawi's health budget is funded by development partners, and many of those funds are earmarked for particular activities. There is therefore very limited scope for assigning resources according to the technical prioritization criteria. There are few levers at policy level to allocate resources so as to affect what is implemented directly. As a result, much health spending is out of line with the prioritized package and national priorities. In addition, data to support both technical prioritization and more granular decision-making is very limited. For example, only 87 of the Essential Health Package's 250+ interventions were supported by sufficient data on disease burden, efficacy of interventions or cost of implementation for consideration in the cost-effectiveness analysis framework.

A small number of development partner-funded interventions were explicitly included in the cost-effectiveness exercise. For example, GAVI funding for essential vaccines and antiretroviral therapy funding from the Global Fund were included because they are considered stable in the medium term; however, less predictable development partner-funded interventions, for which future financing might be withdrawn, were not included. Operational challenges are anticipated in areas such as contraceptive commodities: development partners are likely to continue funding some Essential Health Package interventions in parallel with government, and without proper coordination this could lead to duplication of services and inefficient resource allocation.

The Health Sector Strategic Plan II states that "Essential Health Package provision has been inequitable in practice because failure to fully fund it has meant varying degrees of coverage for different interventions, by level of health care system and geographical location". This has implications for equity. Health workers and the general population have had little knowledge about the Essential Health Package, and many will not be aware of this policy-level prioritization exercise. Combined with resource limitations, the fact that financing or payment is not

linked to the implementation of the package, and that prioritization is not reflected in clinical practice guidelines or the essential medicines list, means that services actually implemented at facility and community levels often fail to reflect these priorities.

Successes: The 2016 revision instituted a reasonably transparent process for designing and prioritizing health services, and brought the package of prioritized services closer to affordability than was previously the case. Evidence from Malawi and comparable settings was used to inform the prioritization process, which in turn was used to inform policy-makers, who added ethical and pragmatic considerations to the technical ranking through an appropriate participatory process. Despite the challenges involved in using this revision to allocate resources or implement the package, the creation of this process, and its perception as an objectively fair process, is a good first step towards prioritizing resources for UHC.

As for service delivery, agreements with the Christian Health Association of Malawi hospitals, who provide health services to 30-40% of the population, have increased access to the benefits package and other services, particularly for the rural poor. The second Health Sector Strategic Plan incorporated the Essential Health Package in 2017, and annual implementation plans are based upon this, which may help to make the benefits specified in the package more accessible in practice.

Reforms, revisions and plans for the future: The government is working to better coordinate resources from the Ministry of Health and development partners in order to reduce gaps in the Essential Health Package through resource tracking data. Several reforms are being considered to carry policy-level decisions to implementation, including revision of provider payment mechanisms, review of the Central Medical Store's procurement processes, classifying items on the essential medicines list as either Essential Health Package or non-Essential Health Package commodities, hospital management reform and a move to performance-based budgeting led by the Ministry of Finance. A new Health Financing Strategy is being developed to define and prioritize some of these options. In addition, the government continues to seek further sources of funding for SRMNCH through mechanisms such as the Global Financing Facility. These efforts are intended to result in alignment with the Essential Health Package, the Health Sector Strategic Plan II and existing aid coordination tools, to avoid these initiatives further fragmenting the financing landscape.

The Health Sector Strategic Plan II indicates that practical implementation of the Essential Health Package will depend on its incorporation into the Essential Medicines List, the Essential Equipment List and Standard Treatment Guidelines, which inform procurement and clinical processes at facilities and in communities. As noted above, ensuring that key SRHR commodities are included in the Essential Medicines List and that national treatment guidelines are in line with WHO clinical guidance offers an important opportunity for SRHR advocates to exert some influence. Policy-makers have also indicated that provider payment mechanisms may be reformed to link more explicitly to the Essential Health Package.

Table 6. Interventions recommended by the Guttmacher-Lancet Commission on SRHR included in/omitted from Malawi's health benefits package

Interventions recommended by Guttmacher-Lancet Commission	Malawi's Essential Health Package: interventions included/omitted
Comprehensive sexuality education*	• Not included
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Injectables • Intrauterine devices • Implants • Pills * • Female sterilization • Male condoms
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Tetanus toxoid (pregnant women) Deworming (pregnant women) • Daily iron and folic acid supplementation (pregnant women) • Syphilis detection and treatment (pregnant women) • Intermittent presumptive treatment (pregnant women) • Insecticide-treated bed net distribution to pregnant women • Urinalysis (four per pregnant woman) • Clean practices and immediate essential newborn care (in facility) • Active management of the 3rd stage of labour • Management of eclampsia/pre-eclampsia (magnesium sulphate, methyldopa, nifedipine, hydralazine) • Neonatal resuscitation (institutional) • Caesarean section with indication • Caesarean section with indication (with complication) • Vaginal delivery, skilled attendance (including complications) • Management of obstructed labour • Newborn sepsis - full supportive care • Newborn sepsis – injectable antibiotics • Antenatal corticosteroids for preterm labour • Maternal sepsis case management • Cord care using chlorhexidine • Hysterectomy • Treatment of antepartum haemorrhage • Treatment of postpartum haemorrhage • Antibiotics for preterm premature rupture of the membranes
Safe abortion services and treatment of complications of unsafe abortion	• Post-abortion case management
Prevention and treatment of HIV and other sexually transmitted infections	• Cotrimoxazole for children • Prevention of mother-to-child transmission of HIV • HIV testing services • HIV treatment for all ages – antiretroviral therapy and viral load
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence	• Not included
Prevention, detection, and management of reproductive cancers, especially cervical cancer	• Human papillomavirus vaccine • Testing of pre-cancerous cells (vinegar)
Information, counselling and services for subfertility and infertility	• Not included
Information, counselling and services for sexual health and well-being	• Not included

* Comprehensive sexuality education is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.

CASE STUDY

NIGERIA

Nigeria's health sector is primarily funded by out-of-pocket spending, which accounts for 70% or more of total health expenditure. Development partner funding amounts to 7% and public funding to 16.5% of total health expenditure.[25] Public funding for health is limited at US$ 32 per capita annually.[26] Total public health spending is 5.3% of total government spending.[27] Nigeria's highly decentralized system of governance gives state and local governments considerable autonomy in setting their own health priorities and allocating resources to health and specific services. Most of the funding from development partners and the government is spent on salaries and tertiary care, or in vertical funds managed by different directorates at different levels of the health system. In addition, the limited funds that are available are not always well managed, resulting in stock-outs, ill equipped health workers and poor quality of care.

As a result of resource shortages, providers charge informal or formal user fees for even the most basic services, such as antenatal visits, which are meant to be free of charge in the public sector. A study in Cross River State found that informal user fees were as high as US$ 2.50 for an antenatal visit.[28] These fees discourage the poor and most in need from seeking care, or exacerbate poverty. One quarter of the population spends more than 10% of household income on health care, more than double the figure for the rest of the continent, and as a result many suffer financial hardship or are pushed below the poverty line by health care costs.

Nigeria has the second highest rates of maternal and newborn mortality globally, with 814 maternal deaths per 100,000 births.[29] Despite many recent efforts to improve maternal health and primary care coverage, key coverage statistics have remained relatively constant. The under-5 mortality rate is high at 100.2 per 1,000 live births. See Table 7 for key demographic and health indicators. With large variations between income quintiles, the poorest carry the heaviest burden.[30] Northern states and remote rural areas also lag far behind in terms of service coverage. To improve access and overall health outcomes, there is a critical need to strengthen health systems and remove user fees that prevent patients from seeking care.[31]

Prioritizing the benefits package: The package of services available is not clearly defined and varies across the country, depending partly on limited funding from development partners and government at the state and local levels and the goals of new

25 World Bank. Financing UHC in Nigeria: rationale, policies, and practices. Presentation. 2018.

26 Ibid.

27 World Bank, 2018. https://data.worldbank.org/indicator

28 Edu BC, Agan TU, Monjok E, Makowiecka K. Effect of free maternal health care program on health-seeking behaviour of women during pregnancy, intra-partum and postpartum periods in Cross River State of Nigeria: mixed method study. Open Access Maced J Med Sci. 2017; 5(3):370–382. doi: 10.3889/oamjms.2017.075

29 Numbers from WHO Global Health Observatory, most recent year available.

30 Ibid.

31 General Disclaimer. Indicator estimates in this case study may differ from those listed on the WHO Global Health Observatory or other UN estimates' websites.

initiatives and schemes. Each funding source (development partners, insurers, government agencies and Ministry of Health departments) may prioritize different services; there is limited coordination between them. Nigeria has recently developed the National Strategic Health Development Plan II (2019-2023) which defines increased utilization of an Essential Package of Health Care Services (EPHCS) as one of its five strategic pillars. This package includes SRHR services, as well as communicable and noncommunicable diseases, mental health and other key areas. Some key areas on SRHR, such as family planning, were included generically, with little detail about specific commodities or levels of service delivery. By contrast, more detail is included about products included in the Essential Medicines List. This package also omits reproductive cancers and services for gender-based violence. Safe abortion services are omitted: induced abortion in Nigeria is prohibited unless the life of the pregnant woman is threatened.

States have also developed State Strategic Development Plans to align with this national plan. However, it is not clear how the benefits they include

Table 7. Nigeria: key demographic and health indicators

Total population (2016)[1]	185,990,000
GNI per capita (PPP international US$, 2013)[1]	5,360
Life expectancy at birth M/F (years, 2016)[1]	55/56
Total expenditure on health as % of GDP (2015)[1]	3.7
Out-of-pocket expenditure as % of current health expenditure (2016)[2]	75
Voluntary health insurance as % of current health expenditure (2016)[2]	1
Nurses & midwives/10,000 pop.(2013)[3]	14.524
Physicians/10,000 pop. (2013)[3]	3.827
Percentage of births attended by skilled health personnel (2013-2017)[4]	43.0
Percentage of married or in-union women of reproductive age whose need for family planning was satisfied with modern methods (2017)[4]	26.3
Abortion at the woman's request (Y/N)[5]	Law varies by jurisdiction

[1] WHO Global Health Observatory https://www.who.int/gho/en/
[2] Global Health Expenditure Database http://apps.who.int/nha/database/Select/Indicators/en
[3] National Health Policy 2016 accessed via WHO Global Health Observatory https://www.who.int/gho/en/
[4] Multiple Indicator Cluster Survey 2016-2017 https://microdata.worldbank.org/index.php/catalog/3002/
[5] Global Abortion Policies Database https://abortion-policies.srhr.org/country/nigeria/

will be financed, and resource shortages often prevent services from being delivered, or being delivered without charge, to the population. In addition, the National Primary Health Care Development Agency has defined a Ward Minimum Package of standard services available at primary health care level, but its implementation has been severely limited, due largely to limitations in resource availability and other challenges.[32]

Given the challenges involved in financing and delivering this National Strategic Health and Development Plan package, the government undertook a new reform, pooling external and government resources to finance and deliver priority services especially for the rural poor. This resulted in the Basic Healthcare Provision Fund (BHCPF), formally launched in January 2019. Resources being limited, the government chose to prioritize key services, including SRHR, and specifically many of the services recommended in the Guttmacher-Lancet Commission on SRHR, for the most vulnerable populations (see Table 8). As in the Strategic Health and Development Plan, services such as safe abortion and management of reproductive cancers were not included.

Participation: The development of the BHCPF, and its inclusion in the 2014 National Health Act, occurred through an iterative multisectoral and multistakeholder process. While the Federal Ministry of Health has the power to define the services to be provided and the population to be covered, development of the benefits package for the BHCPF was conducted through a participatory process involving many stakeholders at different levels, including federal and state government representatives, civil society organizations, development partners and the private sector.

Challenges: This reform is at a very early stage, but significant challenges have already arisen in determining the institutional arrangements for the reform, and for the package itself. While the benefits package has been defined in broad terms, there is insufficient data about service availability and steps

32 A ward is the lowest administrative unit in Nigeria, below that of local government.

necessary to upgrade delivery to provide these services (e.g. training health workers to deliver the services). Many question whether the resources available will be sufficient to deliver and sustain these services.

Successes: The development of the basic minimum package was informed by data on cost-effective interventions that meet the needs of the population, based on evidence of disease burden, poverty and inequality in the country, and available financing across all levels of the system. Considerable thought has been given to designing the BHCPF to tackle financing and supply challenges that hampered the delivery of past reforms. Development partners and the government have earmarked funds to deliver this package, and this has been communicated at all levels of government.

Reforms, revisions and plans for the future: The BHCPF earmarks federal and state level public funding for a defined set of essential health services. Additional funding will initially be received from the Global Financing Facility and the Bill & Melinda Gates Foundation. The government released 25% of the fund for the BHCPF in 2019 and is working with an additional 15 states and the Federal Capital Territory, all of which have indicated readiness to implement the BHCPF for a planned rollout in those states.

The reformed basic minimum package of health services includes nine interventions: four for maternal health (antenatal care, labour and delivery, emergency obstetric and neonatal care and caesarean sections), one for reproductive and adolescent health (family planning), two for under-5s (curative care and immunization), as well as treatment of malaria and screening for select noncommunicable diseases (including cardiovascular and urinalysis tests). Government and development partner funding will be aligned with this package.

The BHCPF was included in the 2014 National Health Act, appropriated in the 2018 budget and formally launched in January 2019. However, the financing systems for this reform still need to be set up to ensure that providers and state and local governments are accountable for and incentivized to provide quality services. In addition, strengthening public service delivery (and/or partnering with the private sector) will be essential to ensure that services can be financed and delivered.

As described above, the design of this reform has been the subject of a consultative process for several years. However, SRHR actors, including civil society, can play a role in increasing awareness of the reform and of the rights and entitlements set out in the National Health Act, and by holding federal and state governments accountable for delivering on this commitment. Evidence is also needed about the logistical requirements for delivery of these services, e.g. in terms of system strengthening. SRHR actors will also have opportunities to influence expansion of this package and broader reform in future.

Table 8. Interventions recommended by the Guttmacher-Lancet Commission on SRHR and their inclusion in/omission from Nigeria's health benefits package

Interventions recommended by Guttmacher-Lancet Commission	Nigeria's Basic Health Care Provision Fund+: interventions included/omitted
Comprehensive sexuality education*	• Not included in the benefits package (nor in previous plans)
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Pills • Condoms • Injectables • Intrauterine devices • Implants
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Antenatal care • Basic and comprehensive emergency obstetric and neonatal care
Safe abortion services and treatment of complications of unsafe abortion	• Not included in the benefits package (nor in previous plans)
Prevention and treatment of HIV and other sexually transmitted infections	• HIV screening • Antiretroviral therapy for mothers and newborns • Note: other sexually transmitted infections were included in previous plans for the public sector • HIV counselling • Safe infant feeding • Counselling for mothers with HIV
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence	• Not included in the benefits package or previous plans for the public sector
Prevention, detection, and management of reproductive cancers, especially cervical cancer	• Not included in the benefits package or previous plans for the public sector
Information, counselling and services for subfertility and infertility	• Not included in the benefits package or previous plans for the public sector
Information, counselling and services for sexual health and well-being	• Not included in the benefits package or previous plans for the public sector

+ The BHCPF has not yet been implemented: services were therefore compared with the previous NHSDP (for the period 2010-2015).
* Comprehensive sexuality education is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.

CASE STUDY

RWANDA

Rwanda's health sector has made significant progress in recent years, increasing its health spending and improving access to care. Maternal mortality has dropped by 80%, from 1,071 deaths per 100,000 live births in 2000 to 210 in 2014/15. 43.9% of pregnant women receive four or more antenatal care visits, and 91% of births are now attended by a skilled practitioner.[33] See Table 9 for key demographic and health indicators.

Rwanda's progress is due to strong national leadership, community-focused primary care, district ownership, continuing sensitization of community health workers, and provision of services by Mutuelle de Santé, a national, publicly financed insurance scheme for the informal sector. This is now managed by the Rwanda Social Security Board, and covers over 85% of the population. An additional 6% of the population are covered by formal medical schemes, so over 90% of the population is covered by some

Table 9. Rwanda: key demographic and health indicators

Total population (2016)[1]	11,918,000
GNI per capita (PPP international US$, 2013)[1]	1,430
Life expectancy at birth M/F (years, 2016)[1]	66/70
Total expenditure on health as % of GDP (2015)[1]	7.5
Out-of-pocket expenditure as % of current health expenditure (2016)[2]	9
Voluntary health insurance as % of current health expenditure (2016)[2]	5
Nurses & midwives/10,000 pop.(2015)[3]	8.307
Physicians/10,000 pop. (2017)[3]	1.346
Percentage of births attended by skilled health personnel (2010-2015)[4]	90.7
Percentage of married or in-union women of reproductive age whose need for family planning was satisfied with modern methods (2014)[4]	65.9
Abortion at the woman's request (Y/N)[5]	N

[1] WHO Global Health Observatory https://www.who.int/gho/en/
[2] Global Health Expenditure Database http://apps.who.int/nha/database/Select/Indicators/en
[3] National Health Workforce Data Platform accessed via WHO Global Health Observatory https://www.who.int/gho/en/
[4] Demographic and Health Survey 2014-2015 https://microdata.worldbank.org/index.php/catalog/2597
[5] Global Abortion Policies Database https://abortion-policies.srhr.org/country/rwanda/

33 Rwanda Demographic Health Survey 2014/15.

form of public health insurance. Utilization of primary health services has increased five-fold, from 0.3[34] visits per capita in 2003 to 1.43[35] in 2015[36].

In 2011 the Ministry of Health reviewed and updated the health services packages provided by the whole health sector. The resulting Service Package for Health Facilities at Different Levels of Service Delivery (Service Package) specifies the services which should be provided at each health facility level, and the inputs required to implement them. Services are broadly defined, but are complemented by national treatment guidelines, clinical protocols and an essential medicines list.

Not all services in this package are exempt from user fees. Members of insurance schemes pay an insurance premium to qualify for services. Members of the Mutuelle de Santé scheme pay a tiered premium and co-payments, with exemptions for the poorest populations. The Mutuelle de Santé package is defined in a Gazette published in 2016, which reflects the Service Package, and can be updated through clinical guidelines and the Essential Medicines List. The government aims to revise this package in the coming years, to align it with patients' needs and to make it sustainable.

Prioritizing the benefits package: All participants in the Mutuelle de Santé scheme receive the same benefits (as outlined in the Gazette). Beneficiaries, who pay premiums and co-payments, are entitled by law to a comprehensive range of preventive and curative services throughout the country in public facilities (there may be a one-month waiting period if the annual premium is paid after the defined registration period). The Ministry of Health has defined the services to be delivered by facility type, based on available staffing and level within the referral system. The benefits package covers both inpatient and outpatient care, and lists essential drugs.

The care available at each level of the health system as is follows.

- Health centres: Minimum package of activities as defined by the government, including curative, preventative, promotional and rehabilitative services. Maternity and inpatient services are included.

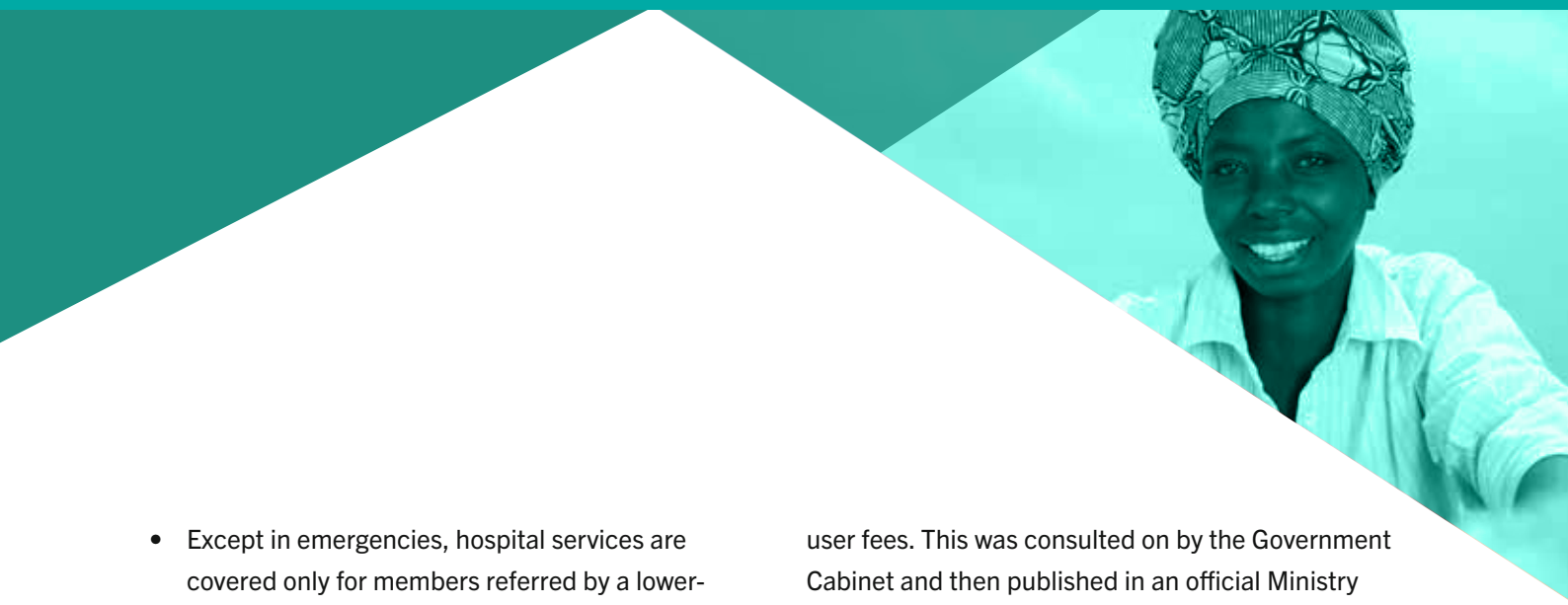
- District hospitals: Complementary package of activities as defined by the government for patients referred from a primary health centre. These include obstetric/gynaecological care, surgery, advanced laboratory services, ophthamology centres and radiology services.

- Tertiary hospitals: Specialized package of tertiary-level activities as defined by the government for patients referred from a district hospital, such as ophthalmology, dermatology, ear, nose and throat, stomatology and physiotherapy, in addition to services available at district hospitals.

34 Some of the data for Rwanda, including this statistic and the breakdown of total spending, are based on past estimates. National Health Accounts Rwanda 2006.

35 Rwanda 2016 Annual Health Statistics Booklet.

36 General Disclaimer. Indicator estimates in this case study may differ from those listed on the WHO Global Health Observatory or other UN estimates' websites.



- Except in emergencies, hospital services are covered only for members referred by a lower-health facility level. Ambulance costs are reimbursed by community-based health insurance where medically necessary and for patients referred from one health facility to another.

- "Patient roaming" allows beneficiaries to access care anywhere in the country.

As illustrated in Table 10, the service package, and in turn the Mutuelle de Santé package, include most of the interventions recommended by the Guttmacher-Lancet Commission on SRHR at high level. Prevention, promotion, information and counselling are not included in the Mutuelle de Santé package, other than some HIV prevention and counselling services. However, the general Ministry of Health service package does include key activities such as behaviour change at community level, paid from the public sector budget. Despite the comprehensiveness of packages covered by community-based health insurers, some services, products and commodities at partnering institutions are not available, requiring insured patients to pay for services and commodities at private establishments. Previously, Mutuelle de Santé contracted only with public health facilities, but has recently begun contracting services from the private sector as well.

Participation: The Ministry of Health is primarily responsible for defining the benefits package and setting prices for the Mutuelle de Santé, based on the Service Package. The Mutuelle de Santé package was initially based on the benefits package and the services already being provided in facilities with user fees. This was consulted on by the Government Cabinet and then published in an official Ministry of Health Gazette, available to the public and key stakeholders. Additions to that package were made in an ad hoc manner (e.g. changes to the essential medicines list). The government aims to increase consultation and inclusivity in the process of modifying this list through a priority-setting process that takes into account the opinions of key actors and key considerations, including affordability and sustainability.

Challenges: Although the Ministry of Health is responsible for decisions about the benefits package, the Rwanda Social Security Board pays for the services. A defined consultative process is needed for developing the benefit package, which includes key stakeholders and considers affordability as well as cost-effectiveness and equity. Although co-payments for the lowest socioeconomic class have been waived, there is a further need to investigate whether co-payments or service delivery barriers prevent other beneficiaries from accessing care.

Successes: Development partner funding is allocated in line with government-defined priorities. For example, external funding contributes to the premium subsidy for the indigent to receive services through the Mutuelle de Santé. This alignment of development partner funding with the service package is possible because the Rwandan government asked development partners to coordinate and allocate funding towards national plans, and to report using the health resource tracking tool (HRTT). Rwanda conducts an annual resource mapping and partner mapping exercise for health sector needs, and asks

development partners to coordinate with these plans. In addition, the Mutuelle de Santé scheme has been highly successful in providing coverage to most of the population.

Reforms, revisions and plans for the future: With the increasing financial constraints on the Mutuelle de Santé, and anticipated development partner transition, the ministries of health and finance are considering a periodic revision of the benefit package. This was clearly stated as a priority in the fourth health sector strategic plan. Such review will provide an entry point for SRHR actors to support the government by developing an evidence-based and robust priority-setting process to inform the package, as well as the essential medicines list and other levers.

Table 10. Interventions recommended by the Guttmacher-Lancet Commission on SRHR and their inclusion in/omission from Rwanda's health benefits package

Interventions recommended by Guttmacher-Lancet Commission	Rwanda Mutuelles Benefits (2016 Gazette): interventions included/ omitted
Comprehensive sexuality education*	• Not included in Mutuelles package. The service package outlines promotional activities at community level but without listing what this includes.
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Injectables • Contraceptive implants (procedure only) • Intrauterine device insertion (procedure only)
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Antenatal care • Delivery and postnatal care • Basic and comprehensive emergency obstetric and neonatal care
Safe abortion services and treatment of complications of unsafe abortion	• Abortion (allowed for pregnancies resulting from rape, incest, forced marriage, or health risk to the woman or fetus) and incomplete abortion are included as a gynaeco-obstetric and neonatal emergency service (including manual vacuum aspiration)
Prevention and treatment of HIV and other sexually transmitted infections	• Screening and treatment of sexually transmitted infections • Screening for HIV (treatment provided predominantly through development partner funding)
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence	• Social psychology: personal and family relationship problems (e.g. family conflicts, violence, intimate partner violence, child abuse/neglect, couple and marriage problems) • Post-exposure prophylaxis • Management of sexual and gender-based violence cases
Prevention, detection, and management of reproductive cancers, especially cervical cancer	• Oncology services including screening and some therapies
Information, counselling and services for subfertility and infertility	• Psychological services only
Information, counselling and services for sexual health and well-being	• Not included in Mutuelles package. The service package outlines promotional activities at community level but without specifying training and activities.

* Comprehensive sexuality education is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.

CASE STUDY

SOUTH AFRICA

South Africa is an upper-middle-income country, with some of the world's widest socioeconomic inequalities. These contribute to poor health outcomes and inequality in access to health care. Poor health in turn aggravates socioeconomic inequalities. Despite spending a relatively large proportion of its GDP on health, the country's health indicators remain poorer than those of other upper-middle-countries with similar or lower levels of expenditure. This is partly due to inequities in health spending, 51% of which provides services to only 16% of the population.[37] Although skilled personnel attend 96.7% of births and 75.5% of pregnant women receive four or more antenatal visits, maternal mortality remains high at 138 per 100,000 live births. The under-5 mortality rate is 40.3 per 1,000 live births.[38] See Table 11 for key demographic and health indicators.[39]

South African law guarantees access to SRHR services. Death from unsafe abortion has declined by more than 90% since the Choice on Termination of Pregnancy Act was passed in 1996. However, the country's maternal mortality rate remains unacceptably high, and many women face obstacles when seeking a safe legal abortion. South Africa still has high rates of HIV and unintended pregnancy. Young women face particular challenges: one in three women aged 15-24 experiences an unintended pregnancy before the age of 20, and among females aged 15-24 HIV incidence is more than four times higher than among males in the same group. Gender-based violence and femicide are among the highest in the world.

Since democracy in 1994, the government has tried to redress inequities in access to health care through policies such as the National Department of Health Strategic Plan 2015–2020 and the National Development Plan. The National Health Insurance (NHI) white paper aims to provide a package of primary health care services to vulnerable populations by 2021 and to the whole population by 2025.[40]

Prioritizing the benefits package: Many benefits packages are available in South Africa, primarily through private health insurers who purchase services from private providers in addition to services available in the public sector. The Medical Schemes Act (No 131 of 198) lists services that all private health insurance schemes must cover. These Prescribed Minimum Benefits are made up of 270 "diagnosis-treatment pairs" together with 27 conditions stipulated in the Chronic Disease List.[41] Different medical schemes and their administrators have each developed a range of benefit options that cover these Prescribed Minimum Benefits plus additional benefits in different forms, based on ability to pay. By

37 WHO. Global Health Expenditure Database, 2014.

38 WHO Global Health Observatory, most recent year available.

39 General Disclaimer. Indicator estimates in this case study may differ from those listed on the WHO Global Health Observatory or other UN estimates' websites.

40 Government of South Africa. National Health Insurance for South Africa, 2017. Available at: http://serve.mg.co.za/content/documents/2017/06/29/whitepaper-nhi-2017compressed.pdf

41 Government of South Africa. Medical Schemes Act, 1998. https://www.medicalschemes.com/files/Acts%20and%20Regulations/MSACT19July2004.pdf

design, these benefits are hospital-centric in nature. In contrast, the services available in the public sector are not governed by any benefits package or list of services, so different interventions may be provided at different facilities, according to the resources available in each location.

Work is currently underway to prepare for NHI by creating a single national benefits package, beginning with primary health care and expanding incrementally to cover all levels of care. At this early stage of NHI transition, the focus is less on prioritization and more on ensuring consistency in definition and thus in quality of services: specifying services to be delivered at each level of the health sector, and costing them in order to inform the development of reimbursement rates, which are particularly relevant to the planned contracting of private sector providers. South Africa's approach to prioritization is to focus on delivering services first at primary health-care level, ensuring that the private sector will also deliver these services at the

Table 11. South Africa: key demographic and health indicators

Total population (2016) [1]	56,015,000
GNI per capita (PPP international US$, 2013) [1]	12,240
Life expectancy at birth M/F (years, 2016) [1]	60/67
Total expenditure on health as % of GDP (2014)[1]	8
Out-of-pocket expenditure as % of current health expenditure[2]	8
Voluntary health insurance as % of current health expenditure[2]	36
Nurses & midwives/10,000 pop. (2017)[3]	35.171
Physicians/10,000 pop. (2017)[3]	9.101
Percentage of births attended by skilled health personnel (2011-2016)[4]	96.7
Percentage of married or in-union women of reproductive age whose need for family planning was satisfied with modern methods (2016)[4]	77.9
Abortion at the woman's request (Y/N)[5]	Y

[1] WHO Global Health Observatory https://www.who.int/gho/en/
[2] Global Health Expenditure Database http://apps.who.int/nha/database/
[3] Estimated health workforce from Labour Force Survey ILO 2018, accessed via WHO Global Health Observatory https://www.who.int/gho/en/
[4] Demographic Health Survey 2016 http://www.statssa.gov.za/publications/Report%2003-00-09/Report%2003-00-092016.pdf
[5] Global Abortion Policies Database https://abortion-policies.srhr.org/south-africa/

appropriate level of the health system. For example, if a service can be delivered at a clinic but is currently only offered at hospital level by a medical scheme, it should in future also be offered at clinic level, so as to increase access and control associated costs. Within primary health care, no prioritization process is currently being conducted, although the government plans eventually to prioritize services based on cost effectiveness. The national benefits package is based on the national Standard Treatment Guidelines for primary health care. These guidelines were updated in 2017 and 2018 from a clinical perspective; they may require further revision as they vary in specificity and will need to be sufficiently precise for the private sector to align their coded diagnoses, (i.e. detailed enough to map to specific International Classification of Diseases and procedure codes). The package incorporates an Essential Medicines List and national Clinical Practice Guidelines. Many of the interventions recommended by the Guttmacher-Lancet Commission on SRHR are included (see Table 12). Efforts are also being made to align and rationalize existing guidelines and to identify gaps to be addressed. An online platform (South Africa Health Benefits) has been developed to consolidate all this information in one place, and is currently in beta testing.

Participation: The introduction of NHI is being led by the Office of the President in collaboration with the National Department of Health. The process of developing the health benefits package is therefore government-led and supported by regulatory agencies, including the regulatory body for private medical schemes (the Council for Medical Schemes) and the Office for Health Standards Compliance. It is also supported by individual private sector partners, including key schemes and administrators. It is further informed by the Competition Commission Health Market Report (2019) which recommends "the introduction of a single comprehensive, standardized base benefit option". In the process of developing South Africa Health Benefits, exploratory analysis has compared the national Clinical Practice Guidelines with the Standard Treatment Guidelines. This includes the Guidelines for Maternal Care in South Africa (2015), the Guidelines for Neonatal Care (2011) and several other instruments. Seventy-six conditions relating to SRHR are captured at primary health-care level in South Africa Health Benefits, and only minor political challenges have been raised to the inclusion of even the most controversial elements of SRHR. Comprehensive primary health care is widely

regarded as a right, and prioritizing some services for inclusion in a package implicitly excludes others; therefore, prioritization has been seen as politically unpalatable. However, the focus on primary health care is itself a form of prioritization; the current process of defining what is meant by primary health care in South Africa is increasing public awareness of and commitment to a defined and transparent process of priority setting.

Challenges: The NHI and Medical Schemes Amendment bills, when enacted, will govern the implementation of a benefits package. The NHI bill was presented to Parliament on August 2019 for approval. The NHI fund has yet to be established, but funding continues for the health system strengthening initiatives that are essential to the rollout of NHI. The election in May 2019 led to the appointment of a new Minister for Health who has affirmed support for NHI. Private sector medical service providers, a powerful lobby, are concerned that their role in the proposed structure has not been clearly defined. Other actors, such as trade unions, are concerned that the fund will not achieve the equity aims set out in the white paper. The white paper focused on addressing inequality by delivering services to poor and vulnerable populations. However, implementation will be administered by provinces, which have considerable autonomy, so the realization of that policy presents a major challenge and will depend on further legislative changes (as outlined in the NHI bill).

Successes: The South Africa Health Benefits database, which sets out the services and inputs covered by the Standard Treatment Guidelines, is now online as an interactive platform. The adoption of a primary health care package has helped to ensure the inclusion of many SRHR interventions, although those delivered at secondary or tertiary level are omitted, as are those delivered outside the health sector. In general, technical and managerial capacity is strong in the private sector but more limited in the public sector at national level. Data of varying quality are available at facility, provincial and national levels and will be used to inform decision-making for the package. The government plans to conduct service availability assessments to identify services not currently available but which should be delivered when the South Africa Health Benefits are fully implemented.

Reforms, revisions and plans for the future: In preparation for NHI, a number of processes have been initiated. An "ideal clinics" initiative has been put in place to measure input and service availability against a target envelope of operational capacity, infrastructure, human resources, medicine stocks and other supplies. Conditional grants were released, prioritizing school health, maternal health, mental health, cataract surgeries and oncology; however, these have since been allocated to other programmes/areas. The National Treasury is designing a capitation system for provider payment, intended to reduce both administration costs and overprovision of services compared with a fee-for-service model. A coalition of universities and academic partners is building capacity to provide expertise in setting up processes to design and prioritize services institutionally. The NHI white paper states that interventions will be added, based on criteria including cost-effectiveness and equity, and the related bill has been presented to Parliament for approval. The National Tertiary Services Grant, which allocates funds between 28 tertiary-level hospitals across all provinces, is being reviewed to make the allocation formula and process more strategic and more reflective of health and population data. SRHR actors could exert influence here by mobilizing and/or generating evidence on resource gaps for SRHR service availability, to inform the allocation of funds from this grant, and from the NHI Fund once it is established.

Table 12: Overview of interventions recommended by the Guttmacher-Lancet Commission on SRHR and their inclusion in/omission from South Africa's health benefits package

Interventions recommended by Guttmacher-Lancet Commission	South Africa Health Benefits and Standard Treatment Guidelines - interventions included/omitted
Comprehensive sexuality education[1]	• Not included
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Emergency contraception • Family planning – IUCD • Family planning – medroxyprogesterone injection (Depo Provera) • Family planning – norethisterone enanthate injection (Nur-Isterate) • Family planning – oral pill • Family planning – subdermal implant
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Eight antenatal care visits • Antenatal care: anaemia in pregnancy • Antenatal care: care of the HIV-infected pregnant woman • Antenatal care: hypertensive disorders of pregnancy – eclampsia • Antenatal care: hypertensive disorders of pregnancy – hypertension, chronic/ mild-moderate and severe • Antenatal care: hypertensive disorders of pregnancy – pre-eclampsia • Antenatal care: syphilis in pregnancy • Bleeding in pregnancy: antepartum haemorrhage • Abnormalities in the first, second, third and fourth stages • Bleeding in pregnancy: management of incomplete miscarriage in the first trimester at primary health care level • Bleeding in pregnancy: miscarriage • Breech presentation and transverse lie during pregnancy • Urinary tract infection in pregnancy, cystitis • Vaginal bleeding: abnormal vaginal bleeding during fertile years • Vaginal discharge/ lower abdominal pain in women • Genital ulcer syndrome in pregnancy • Postpartum haemorrhage • Premature rupture of membranes at term • Preterm labour • Preterm prelabour rupture of membrane • Puerperal sepsis • Ulcers, vaginal • Care of the neonate: neonatal resuscitation • Care of the neonate: routine care of the neonate • Care of the neonate: sick neonate and neonatal emergencies • Neonatal apnoea • Neonatal convulsions • Neonatal jaundice • Congenital pneumonia • Cracked nipples during breastfeeding • Dysmenorrhoea • Ectopic pregnancy • Hormone therapy • Intrapartum care (normal delivery) • Intrauterine death, stillborn babies and neonatal deaths • Intrauterine growth restrictions • Management of deep vein thrombosis in pregnancy • Mastitis
Safe abortion services and treatment of complications of unsafe abortion	• Bleeding in pregnancy: management of incomplete miscarriage in the first trimester (includes termination of pregnancy at <9 weeks, 9-12 weeks, 12+ weeks)

Prevention and treatment of HIV and other sexually transmitted infections	• Antiretroviral therapy, first and second line, adults and children • Post-exposure prophylaxis • Male circumcision • Pre-exposure prophylaxis (from Standard Treatment Guidelines) • Balanitis/ balanoposthitis • Bubo • Genital molluscum contagiosum • Genital ulcer syndrome • Genital warts, condylomata acuminata • Male urethritis syndrome • Pubic lice • Scrotal swelling • Syphilis serology and treatment • Vaginal discharge syndrome • Vaginal discharge/lower abdominal pain
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence	• Rape and sexual violation
Prevention, detection, and management of reproductive cancers, including cervical cancer and breast cancer	• Not included in Standard Treatment Guidelines but plans to include these services through other clinical guidelines and national policies[2]
Counselling on fertility and infertility	• Not included in Standard Treatment Guidelines but plans to include these services through other clinical guidelines and national policies[3]
Counselling and information on sexual health	• Not included in Standard Treatment Guidelines but plans to include these services through other clinical guidelines and national policies[4]

[1] Comprehensive sexuality education is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.
[2] Guideline document Cervical Cancer Screening in South Africa 2015. Clinical guidelines for breast cancer control and management.
[3] Department of Health, Republic of South Africa. 2012. National Contraception and Fertility Planning Policy and Service Delivery Guidelines. December 2012. Department of Health, Republic of South Africa.
[4] Department of Health, Republic of South Africa. 2015. National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults. April 2015. Department of Health, Republic of South Africa.

LESSONS LEARNED FROM THE CASE STUDIES

Based on the cases studies, and in collaboration with policy-makers in the six countries, six lessons were learned. These lessons illuminate the current standing of SRHR in benefits packages, the processes for developing these packages, and related opportunities and challenges.

Essential SRHR interventions and services are not entirely captured in health benefits packages

The essential set of SRHR interventions is not included in any of the six countries' health benefits packages. The reasons for this are varied, and may be linked to political sensitivities (e.g. safe abortion care) or allocation of responsibility between ministries (e.g. comprehensive sexuality education). Additionally, a focus on curative rather than preventive/promotive care may be responsible for the omission of information and counselling and services related to SRHR. Where SRHR services linked to prevention/promotion are available, these often focus on voluntary HIV counselling and testing, or counselling on family planning and sexually transmitted infections. However, where these activities were funded and implemented in collaboration with development partners in vertical programmes, they are often omitted from the health benefits package. Other services, such as those related to broader sexual health and well-being, may not be prioritized, or viewed as inappropriate for some groups (e.g. unmarried people, adolescents). Further research is needed to discover why some services are consistently excluded from benefits packages.

Different processes for developing health benefits packages lead to different packages

In order to develop and deliver an essential package of SRHR interventions, several different processes are necessary. Decisions related to the design of health benefits package are often made across several government agencies. As a result, it is not always clear who is responsible for a decision, and what decision-making process was followed.

Each country approaches the process from a different starting point and in a different way. One pragmatic approach is to start by aligning existing private sector health insurance minimum benefits with a theoretical public package at the primary health care level (as seen in South Africa). Alternatively, a country could conduct a technical, evidence-based analysis of the cost-effectiveness of full coverage of a wide range of health interventions, weighing disease burden and epidemiology against the cost of delivering services, and assessing the relative affordability and/or tradeoffs of choosing one intervention over another (as was done in Malawi). These two different processes will result in two different SRHR packages. Basing an approach on private sector health services, or an insurance scheme, may lead to greater prioritization of more medical and commodity-based services. On the other hand, relying more heavily on an existing evidence base may result in undervaluing interventions on which fewer data are available.

Health financing decision-making is unaligned, making resource allocation for comprehensive health benefits packages more complicated

There is limited alignment between development partner funds and national priorities (as enumerated in the government budget). Many development partners earmark assistance for specific programmes, which are not always aligned with the priorities of national health benefits packages. Such earmarked funding in countries highly dependent on external assistance complicates UHC reform, despite the

recent plateauing of development assistance for health. As external funding decreases, many countries are likely to struggle to mobilize financial resources to add development partner-funded interventions back into the package, undermining a comprehensive UHC approach to service delivery.

In terms of domestic funding, decisions affecting health budgets are often made by government agencies outside of the ministry of health (e.g. by the finance ministry, civil service, insurance and/or procurement agencies) and at various levels (by federal, regional or district governments). However, when health benefits packages are developed those other agencies with direct or indirect control over the health budget may not be at the table. As a result, decisions on resource allocation may not be in line with the service package designed.

Supply-side challenges must be considered when prioritizing SRHR interventions

Service delivery is often overlooked when national-level policies are developed. Services might be prioritized without consideration of supply-side constraints, or of requirements for upgrading service delivery systems (e.g. the supply chain for drugs and other commodities to health centres, or the training of health workers to ensure adequate staffing and good-quality services). As a result, governments may commit to provide services that in practice are not consistently available in the public sector. Unanticipated supply-side challenges can hinder both the allocation of adequate resources to SRHR and the delivery of prioritized interventions.

Practical considerations, such as guidelines on diagnosis and treatment for health providers, and availability of drugs at health facilities, are essential to the successful delivery of health services. One of the most important factors for ensuring drug availability in the public sector is a country's essential medicines list, which specifies the drugs to be provided to health facilities. Another essential set of regulations, national clinical practice guidelines specify the services which health providers must be trained to deliver, and stipulate diagnosis and treatment protocols. SRHR services which are not covered by the clinical practice guidelines and essential medicines list are less likely to be provided, even if they are included in the essential health package.

Therefore, for stakeholders aiming to influence the benefits package, and thus the services financed and delivered, it is vital to ensure that the essential medicines lists and clinical practice guidelines cover SRHR commodities (for example, the full range of modern contraceptive commodities) and are aligned with World Health Organization technical guidance and clinical guidance for SRHR interventions.

The level of detail about interventions included in country packages varies widely

Table 13 below demonstrates this variation in respect of prevention and treatment of HIV and other sexually transmitted infections.

How explicit a benefits package should be depends on how it will be used. A loosely defined benefits package can result in informal rationing: health service providers are forced to decide how to treat patients because they lack sufficient resources to

Table 13. Interventions for the prevention and treatment of HIV and other sexually transmitted infections in national benefits packages

	Prevention and treatment of HIV and other STIs
South Africa	• ART first and second line for adults and children • PEP • Male circumcision • PrEP (from Standard Treatment Guidelines) • Balanitis/ Balanoposthitis • Bubo • Genital molluscum contagiosum • Genital ulcer syndrome • Genital warts (Condylomata acuminata) • Male urethritis syndrome • Pubic lice • Scrotal swelling • Syphilis serology and treatment • Vaginal discharge syndrome • Vaginal discharge/lower abdominal pain
Eswatini	• PMTCT • HIV testing and screening • ART initiation • ART refills • STIs
Malawi	• Cotrimoxazole for children • PMTCT • HIV testing services • HIV treatment for all ages – ART and viral load
Nigeria	• HIV screening • ART for mothers and newborns • Note: other STIs are included in previous plans for the public sector • HIV counselling • Safe infant feeding • Counselling for mothers with HIV
Rwanda	• Screening for and treatment of STIs • Screening for HIV (treatment is provided predominantly through development partner funding)
Ethiopia	• Health post: IEC and counselling on HIV/AIDS, support and guidance on home-based care, VCT • Health centres: screening and counselling on STIs/HIV/AIDS; PMTCT; treatment of AIDS and OIs • District hospitals: VCT; diagnosis and ARV treatment; treatment of OIs; PMTCT

ART= antiretroviral therapy; IEC=information, education and communication; OIs=opportunistic infections; PEP=post-exposure prophylaxis; PMTCT=Prevention of mother-to-child transmission of HIV; PrEP=pre-exposure prophylaxis; STIs=sexually transmitted infections; VCT=voluntary counselling and testing.

provide all services to the entire population. On the other hand, producing more explicit packages requires significantly more information about patient needs and supply-side constraints in order to develop rules and guidelines governing which services should be provided to whom, under what conditions.

These differences are extremely important when it comes to implementation, and how directly the packages can be used to inform revisions of essential medicines lists and clinical practice guidelines. They are also important when aligning different benefits packages, for example public and private insurance schemes. Less specificity in a package allows more flexibility to include expensive treatments or deliver unnecessarily high levels of care. It could also allow discrimination against particular populations or patient groups, for example those with HIV/AIDS. Most countries are gradually making their benefits package more explicit, based on available information, how the package will be used and whether it can be enforced.

Better country-level data are needed, as well as greater capacity to analyse existing data

A great deal of work has been done to improve data generation and use at global and regional levels. However, insufficient country-specific data are available on both the cost of delivering interventions in a given setting (which varies considerably between countries) and the effectiveness of interventions in that setting. Additionally, data disaggregation (by age, gender and other key variables), essential for proper consideration of gender and equity issues in prioritization processes, is often impossible due to inadequate capacity or data systems. High-quality national- and subnational-level data are vital in order to achieve informed prioritization, given the large differences between countries and between populations within countries. Decision-makers can only be influenced by data which are properly compiled, analysed and presented.

RECOMMENDATIONS

1. The Guttmacher-Lancet Commission's recommended SRHR interventions can be used as a benchmark to measure a country's progress towards delivering an essential package of SRHR services.

2. A transparent and participatory process should be established for defining and iterating health benefits packages. Broad stakeholder participation is essential for health benefits package design, in order to: improve the legitimacy and accountability of decision-making processes; improve the quality of decisions by providing more information on preferences and values; promote consistency across decisions; and educate society about their rights and the constraints faced by decision-makers.

   Stakeholders should include all government ministries and agencies with responsibility for implementing *and funding* interventions intended to achieve a country's SRHR goals. Civil society, private-sector health systems counterparts, provider groups and patient groups should also be included, especially those representing populations who may otherwise struggle to access care.

3. All stakeholders involved in health benefits package design need to be equipped with the skills necessary to participate meaningfully. Capacity building is needed for package design, prioritization and implementation. Which groups require which skills will vary by country. Countries that have successfully set up inclusive and transparent processes, institutions and communication approaches can share their experiences to help build capacity in countries facing similar challenges.

4. Service prioritization for health benefits packages should take account of information on service availability and facility readiness assessments. Costed investment plans for health system strengthening should be developed, and capacity of technical government staff should be increased to ensure ongoing quality management and private sector engagement.

5. Resources from development partners should be better aligned and coordinated with interventions specified in national health benefits packages in order to improve the predictability of funding for prioritized services over the long term.

6. Benefits package interventions should be reflected in countries' essential medicines lists and clinical practice guidelines, which have the advantages of specificity and alignment with the existing day-to-day work and incentives of health workers. Aligning benefits packages with these regulatory documents will require governments to take a detailed, step-wise approach to implementing policy. This will help identify and address supply-side bottlenecks, enabling delivery of the highest-priority services.

CONCLUSION

This document and the associated country case studies show how a health benefits package can be developed, and how SRHR interventions can be included in that process. These findings show that significant efforts are needed to ensure that an essential set of SRHR interventions is included in health benefits packages and that this inclusion translates to service delivery on the ground. The process of incorporating SRHR into a benefits package is not a one-off activity. Governments need to keep the package under review to ensure that it reflects ongoing changes in resource and service availability. It is also not sufficient to include SRHR interventions in health benefits packages on paper only: they must also be realized in practice. To achieve this, not only the ministry of health but also other local and national stakeholder organizations, will need to use the health benefits package to guide resource allocation and service delivery.

Annex 1: Interventions recommended by the Guttmacher-Lancet Commission on SRHR and their inclusion in/omission from countries' health benefits packages

South Africa Health Benefits and Standard Treatment Guidelines: interventions included/omitted	
Comprehensive sexuality education[1]	• Not included
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Emergency contraception • Family planning – intrauterine device • Family planning - medroxyprogesterone injection (Depo Provera) • Family planning - norethisterone enanthate injection (Nur-Isterate) • Family planning - oral pill • Family planning - subdermal implant
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Antenatal care (eight visits) • Antenatal care: anaemia in pregnancy • Antenatal care: care of the HIV-infected pregnant women • Antenatal care: hypertensive disorders of pregnancy (eclampsia) • Antenatal care: hypertensive disorders of pregnancy (hypertension, chronic/mild-moderate and severe) • Antenatal care: hypertensive disorders of pregnancy (pre-eclampsia) • Antenatal care: syphilis in pregnancy • Bleeding in pregnancy: antepartum haemorrhage • Abnormalities in the first, second, third and fourth stages • Bleeding in pregnancy: management of incomplete miscarriage in the first trimester at primary health care level • Bleeding in pregnancy: miscarriage • Breech presentation and transverse lie during pregnancy • Urinary tract infection in pregnancy, cystitis • Vaginal bleeding: abnormal vaginal bleeding during fertile years • Vaginal discharge/ lower abdominal pain in women • Genital ulcer syndrome (in pregnancy) • Postpartum haemorrhage • Premature rupture of membranes at term • Preterm labour • Preterm prelabour rupture of membrane • Puerperal sepsis • Ulcers, vaginal • Care of the neonate: neonatal resuscitation • Care of the neonate: routine care of the neonate • Care of the neonate: sick neonate and neonatal emergencies • Neonatal apnoea • Neonatal convulsions • Neonatal jaundice • Congenital pneumonia • Cracked nipples during breastfeeding • Dysmenorrhoea • Ectopic pregnancy • Hormone therapy • Intrapartum care (normal delivery) • Intrauterine death, stillborn babies and neonatal deaths • Intrauterine growth restrictions • Management of deep vein thrombosis in pregnancy • Mastitis
Safe abortion services and treatment of complications ofunsafe abortion	• Bleeding in pregnancy: management of incomplete miscarriage in the first trimester (includes termination of pregnancy at <9 weeks, 9-12 weeks, 12+ weeks)

Prevention and treatment of HIV and other sexually transmitted infections (STIs)	• ART first and second line for adults and children • PEP • Male circumcision • PrEP (from Standard Treatment Guidelines) • Balanitis/balanoposthitis • Bubo • Genital molluscum contagiosum • Genital ulcer syndrome • Genital warts (condylomata acuminata) • Male urethritis syndrome • Pubic lice • Scrotal swelling • Syphilis serology and treatment • Vaginal discharge syndrome • Vaginal discharge/lower abdominal pain
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence (SGBV)	• Rape and sexual violation
Prevention, detection, and management of reproductive cancers, including cervical cancer and breast cancer	• Not included in Standard Treatment Guidelines but plans to include these services through other clinical guidelines and national policies[3]
Counselling on fertility and infertility	• Not included in Standard Treatment Guidelines but plans to include these services through other clinical guidelines and national policies[4]
Counselling and information on sexual health	• Not included in Standard Treatment Guidelines but plans to include these services through other clinical guidelines and national policies[5]
Eswatini Essential Health Care Package: interventions included/omitted	
Comprehensive sexuality education[1]	• Not included
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Family planning • Adolescent reproductive health
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Antenatal and postnatal care • Delivery and newborn care
Safe abortion services and treatment of complications of unsafe abortion	• Not included
Prevention and treatment of HIV and other sexually transmitted infections (STIs)	• Prevention of mother-to-child transmission of HIV • HIV testing and screening • Antiretroviral therapy initiation • Antiretroviral refills • Sexually transmitted infections

Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence (SGBV)	• Not included
Prevention, detection and management of reproductive cancers, especially cervical cancer	• Screening (palpation) • Pap smear/visual inspection with acetic acid • Cryotherapy • Cervical cytology
Information, counselling and services for subfertility and infertility	• Not included
Information, counselling and services for sexual health and well-being	• Not included
Malawi **Essential Health Package: interventions included/omitted**	
Comprehensive sexuality education[1]	• Not included
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Injectables • Intrauterine device • Implants • Pills • Female sterilization • Male condoms
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Tetanus toxoid (pregnant women) • Deworming (pregnant women) • Daily iron and folic acid supplementation (pregnant women) • Syphilis detection and treatment (pregnant women) • Intermittent presumptive treatment (pregnant women) • Insecticide treated net distribution to pregnant women • Urinalysis (four per pregnant woman) • Clean practices and immediate essential newborn care (in facility) • Active management of the third stage of labour • Management of eclampsia/pre-eclampsia (magnesium sulphate, methyldopa, • Nifedipine, hydralazine) • Neonatal resuscitation (institutional) • Caesarean section with indication • Caesarean section with indication (with complication) • Vaginal delivery, skilled attendance (including complications) • Management of obstructed labour • Newborn sepsis - full supportive care • Newborn sepsis – injectable antibiotics • Antenatal corticosteroids for preterm labour • Maternal sepsis case management • Cord care using chlorhexidine • Hysterectomy • Treatment of antepartum haemorrhage • Treatment of postpartum haemorrhage • Antibiotics for preterm premature rupture of membranes
Safe abortion services and treatment of complications of unsafe abortion	• Post-abortion case management

Prevention and treatment of HIV and other sexually transmitted infections (STIs)	• Cotrimoxazole for children • Prevention of mother-to-child transmission of HIV • HIV testing • HIV treatment for all ages (antiretroviral therapy and viral load)
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence (SGBV)	• Not included
Prevention, detection and management of reproductive cancers, especially cervical cancer	• Human papillomavirus (HPV) vaccine • Testing of precancerous cells (vinegar)
Information, counselling and services for subfertility and infertility	• Not included
Information, counselling and services for sexual health and well-being	• Not included
Nigeria Basic Health Care Provision Fund[2]: interventions included/omitted	
Comprehensive sexuality education[1]	• Not included in the benefits package or previous plans
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Pills • Condoms • Injectables • Intrauterine device • Implants
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Antenatal care • Basic and comprehensive emergency obstetric and neonatal care
Safe abortion services and treatment of complications of unsafe abortion	• Not included in the benefits package or previous plans
Prevention and treatment of HIV and other sexually transmitted infections (STIs)	• HIV screening • ART for mothers and newborns • Note: other STIs are included in previous plans for the public sector • HIV counselling • Safe infant feeding • Counselling for mothers with HIV
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence (SGBV)	• Not included in the benefits package or previous plans for the public sector
Prevention, detection and management of reproductive cancers, especially cervical cancer	• Not included in the benefits package or previous plans for the public sector

Information, counselling and services for subfertility and infertility	• Not included in the benefits package or previous plans for the public sector
Information, counselling and services for sexual health and well-being	
Rwanda Mutuelles Benefits (2016 Gazette): interventions included/omitted	
Comprehensive sexuality education[1]	• Not included in Mutuelles package. The service package outlines promotional activities at community level but without specifying what this includes.
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Injectables • Contraceptive implants (procedure only) • Intrauterine device insertion (procedure only)
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Antenatal care • Delivery and postnatal care • Basic and comprehensive emergency obstetric and neonatal care
Safe abortion services and treatment of complications of unsafe abortion	• Abortion (allowed for pregnancies resulting from rape, incest, forced marriage or health risk to the woman or fetus) and incomplete abortion are included as a gynaeco-obstetric and neonatal emergency service (including manual vacuum aspiration)
Prevention and treatment of HIV and other sexually transmitted infections (STIs)	• Screening and treatment of STIs • Screening for HIV (treatment provided predominantly through development partner funding)
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence (SGBV)	• Social psychology: personal and family relationship problems (e.g. family conflicts, violence, intimate partner violence, child abuse/neglect, couple and marriage problems) • Post-exposure prophylaxis • Management of SGBV cases
Prevention, detection and management of reproductive cancers, especially cervical cancer	• Oncology services, including screening and some therapies
Information, counselling and services for subfertility and infertility	• Psychological services only
Information, counselling and services for sexual health and well-being	• Not included in Mutuelles package. The service package outlines promotional activities at community level but without specifying training and activities

Ethiopia Government and development partner financed Essential Service Package (2005): interventions included/omitted	
Comprehensive sexuality education[1]	• Not included
Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods	• Health posts: counselling and provision of condoms, mini pills, combined pills and injectables • Health centres: provision of long-term contraceptives including Norplant, Intrauterine device • District hospitals: provision of all forms of family planning, including permanent methods; treatment of abnormal menstruation, including D&C • Community-level activities include family planning information and services and activities during pregnancy and breastfeeding
Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care	• Health posts: antenatal care and follow-up of pregnant women; provision of supplements; information, education and communication (IEC) • Health centres: comprehensive antenatal care; screening and management of pregnancy conditions; management of complications in neonate • District hospitals: skilled intervention for high-risk mothers, including in-patient and maternity waiting area
Safe abortion services and treatment of complications of unsafe abortion	• Health centres: management of abortion including manual vacuum aspiration • District hospitals: management of complications
Prevention and treatment of HIV and other sexually transmitted infections (STIs)	• Health posts: IEC and counselling on HIV/AIDS, support and guidance on home-based care, voluntary counselling and testing (VCT) • Health centres: screening and counselling on STIs/HIV/AIDS; prevention of mother-to-child transmission of HIV (PMTCT); treatment of AIDS and opportunistic infections (OIs) • District hospitals: VCT; diagnosis and ARV treatment; treatment of OIs; PMTCT
Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence (SGBV)	• Not included in essential health service package
Prevention, detection and management of reproductive cancers, especially cervical cancer	• Not included in essential health service package
Information, counselling and services for subfertility and infertility	• Not included in essential health service package
Information, counselling and services for sexual health and well-being	• Health posts provide IEC and counselling on sexuality and related issues, including HIV/AIDS and HIV testing and prevention

[1] CSE is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.
[2] Implementation of the BHCPF is yet to commence. Therefore, anything omitted was checked against the previous NHSDP 2010-2015.
[3] Guideline document Cervical Cancer Screening in South Africa 2015. Clinical guidelines for breast cancer control and management.
[4] Department of Health, Republic of South Africa. 2012. National Contraception and Fertility Planning Policy and Service Delivery Guidelines. December 2012. Department of Health, Republic of South Africa.
[5] Department of Health, Republic of South Africa. 2015. National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults. April 2015. Department of Health, Republic of South Africa.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