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## STATUS OF ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES

### Introduction

1. During the 30th Pan American Sanitary Conference, Member States requested the Pan American Sanitary Bureau to report on the status of access to sexual and reproductive health (SRH) services in the Region of the Americas. This report provides a situation analysis, identifies existing health responses and access barriers, and proposes evidence-based measures to improve the situation.

### Background

2. Sexual and reproductive health is a general state of physical, mental and social wellbeing, and not merely the absence of disease, in all matters relating to the reproductive system and its functions and processes. This includes the right to enjoy a satisfying sex life free from all coercion, discrimination, and violence, with the freedom to decide on procreation (1).

3. Sexual and reproductive health services must fundamentally ensure: *a)* access to information; *b)* the availability of safe, effective, and affordable contraceptive methods; *c)* health care that minimizes risks in pregnancy and childbirth and facilitates access to safe abortion in cases permitted by law; *d)* care of the sexual and reproductive system and treatment of its diseases; *e)* menstrual health; and *f)* gender transitions and the bodily integrity of the intersex population.

4. The Member States of the Pan American Health Organization (PAHO) are committed to targets 3.7 and 5.6 of the Sustainable Health Agenda for the Americas 2018–2030, both linked to SRH, and to the Strategy for Universal Access to Health and Universal Health Coverage (2), which recognizes that all people and communities must have access, without any kind of discrimination, to comprehensive, appropriate and timely, quality health services and supplies. This report is aligned with the Plan of Action for Women's, Children's and Adolescents' Health 2018–2030 (3), whose indicators and

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targets are guiding references. Countries and territories have also committed to addressing the causes of disparities in access to and utilization of health services by lesbian, gay, bisexual, and transgender (LGBT)<sup>1</sup> persons, with full respect for dignity and human rights, taking into account the diversity of gender expression and gender identity, without discrimination (4).

5. The PAHO Strategic Plan 2020–2025 includes indicators to monitor progress toward access to SRH services linked to Sustainable Development Goals 3 and 5, as well as target 1.4 of the Sustainable Health Agenda for the Americas 2018–2030. PAHO Member States, for their part, have adopted plans of action and strategies on SRH, with special attention to populations in situations of vulnerability. Existing SRH data, plans, initiatives, and scientific articles and publications by United Nations agencies were reviewed and systematized to prepare this report.

### **Situation Analysis**

6. Most countries and territories in the Region of the Americas have improved their coverage of access to SRH services, with a focus on primary health care. In 2021, the coverage of essential reproductive, maternal, newborn, and child health services was 81.3% in the Region, 7.3 points above the global average of 74.0%. These indicators are unequal among the different countries of the Region, and marginalized and vulnerable populations present worse outcomes. In the same year, the composite coverage index for these services ranged from 37.9% to 84.5% in the lowest income quintile of the population, and 65.3% to 89.6% in the highest quintile (5–7).

7. Like most aspects of public health, SRH was negatively affected by the COVID-19 pandemic to the extent that urgent assessment is required to implement specific actions. The health emergency affected people's living conditions and their prevention and health care behaviors, while also weakening health services' response capacity. The capacity of public institutions to collect and analyze disaggregated data was diminished. Despite efforts made, most countries have not yet recovered pre-pandemic levels of health coverage and are facing a prolonged health crisis. In the May 2023 interim report on the fourth round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic, 22 countries in the Region reported disruptions in essential sexual, reproductive, and maternal and child health services (8). However, the digital transformation of the health sector since the beginning of the pandemic concurrently led to safe, legal, and sustainable telehealth services, partially mitigating access barriers (9).

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<sup>1</sup> PAHO uses the acronym "LGBT" in accordance with Resolution CD52.R6 (2013), Addressing the Causes of Disparities in Health Service Access and Utilization for Lesbian, Gay, Bisexual, and Trans (LGBT) Persons. It is important to note that the acronym has changed over the years to include other sexual orientations and gender identities. For example, the United Nations uses LGBTQI+, referring to Lesbian, Gay, Bisexual, Transexual, Queer, Intersex, and (+). The symbol (+) is meant to cover a broader range of sexual orientations and gender identities (asexual and pansexual, among others).

### ***Contraception***

8. Universal access to contraception has been enshrined in global and regional commitments since the 1994 International Conference on Population and Development, which recognized the right of individuals to plan for future reproduction with the understanding that access to contraception prevents unintended pregnancies and unsafe abortions.

9. Prior to the COVID-19 pandemic, an increase in contraceptive use among women of reproductive age (modern contraceptive prevalence rate) was observed, alongside a reduction in the global fertility rate. Unmet contraceptive needs were also declining steadily, although more so among married people than those of reproductive age in general (10). Indicator 3.1.2 of the plan of action (3) evaluates the number of countries that measure the percentage of women of reproductive age who have their family planning needs satisfied with modern methods. Only 10 of 23 countries in Latin America and the Caribbean met at least 80% of the demand for contraception with modern, long-acting methods, and strong inequities were observed between and within countries. The use of modern contraceptive methods ranged from 26% in Haiti to 36% in Bolivia, 63% in Argentina, and 68% in Brazil. Within countries, gaps were observed based on ethnicity (Indigenous and Afrodescendant people), age, and socioeconomic status (11). Population-based data on condom use among young people are limited. These data are collected through surveys such as Multiple Indicator Cluster Surveys (MICS) and the Demographic and Health Survey (DHS), and in most cases only for women. Available data collected between 2012 and 2019 in four Latin American and Caribbean countries indicated that the percentage of condom use in the most recent premarital sexual relations between young people aged 15–24 ranged from 51% to 63% among women and between 64% and 88% among men. Similarly, the percentage of young people in this age group who reported using condoms in their most recent sexual relations with a non-marital and non-cohabiting partner ranged from 41% to 79% in women and between 68% and 88% in men, in nine countries in Latin America and the Caribbean (12).

10. A 2019 study found that use of long-acting reversible contraceptives was low in Latin America and the Caribbean: in 17 of 23 countries, use of intrauterine devices (IUD) and subdermal implants was below 10%. Youths aged 15 to 17, indigenous and Afrodescendant women, and those in the lowest wealth quintiles, living in rural areas, and without formal education showed even less use of long-acting reversible contraceptives (11). With regard to contraceptive demand met with modern methods, a 2022 analysis of national surveys from 10 countries in Latin America and the Caribbean showed an absolute gap between Afrodescendants and non-Afrodescendants, ranging from 0.7% in Ecuador to 20.1% in Suriname (13).

11. The COVID-19 pandemic heavily impacted access to contraceptives. An estimated 12.9 to 20.1 million women in Latin America and the Caribbean were forced to discontinue contraceptive use during the pandemic (14). The interruption was caused by disruptions to public provision and difficulty in affording contraceptive methods (8, 14).

12. Countries and territories in the Region are implementing national SRH policies that include providing modern contraceptive methods to women of reproductive age with public or private insurance. These are basic baskets with a wide range of methods, and—with certain disparities between countries—various professionals are authorized as providers (except in cases of long-term and non-reversible methods) (15, 16). By 2022, the target for indicator 3.1.8 of the plan of action had been met with respect to the number of countries and territories with policies in place to promote women having informed, voluntary, and non-coercive access to the family planning method of their choice (17).

13. Despite these efforts, public programs that offer access to contraception provide very low coverage. If effective coverage is considered (coverage levels corrected for the clinical efficacy rate of each method and observed adherence after one year), protection levels are even lower, ranging from 2% to 41% (18). About half of women who use modern contraceptive methods purchase them from pharmacies as an out-of-pocket expense, with significant variations by country; the proportion of users receiving contraception free of charge (through public programs or health insurance) varies from 32.2% in Argentina to 68.6% in Mexico (16).

14. There are many access barriers to contraception: *a*) regulatory and legal frameworks (especially those restricting autonomy for girls and adolescents); *b*) lack of funding for the methods and/or services associated with their use; *c*) complex administrative procedures for provision and unclear medical instructions; *d*) disruptions in the availability of supplies; *e*) lack of workers in health services, and low sustainability of public resources for acquiring and providing modern methods; *f*) lack of confidentiality and privacy; *g*) barriers to mobilization; *h*) social values that hinder access to sex education; and *i*) unfriendly attitudes in health teams. Other factors include weak legal and regulatory frameworks that fail to ensure program assessment (public oversight and unequal gender norms), and insufficient empowerment of women in situations of vulnerability (19, 20).

15. There has been no substantive progress in national information systems toward measuring the proportion of contraception needs met with modern methods (in 2022, only seven countries reported having measured this indicator, falling short of the target of 12 countries for that year). This information is collected through population-based surveys, therefore pandemic restrictions may explain the delay in the availability of this data. As of 2017, according to PAHO's baseline survey, no country had data for this indicator that was disaggregated by age or other social determinants (17).

### ***Adolescent pregnancy***

16. Adolescent pregnancy is a consequence of infringement of the right to education, sex education, access to SRH information and effective contraception, a life free of violence of all kinds, and free and informed decision-making about sex and reproduction. Early motherhood negatively affects the life trajectory of women, as it is associated with school dropout, difficulties in entering the labor market, and access to quality jobs, all of which leads to lower income levels throughout life, in turn impacting the productivity of countries. Adolescent pregnancy also causes health problems (such as increased risk of

maternal morbidity and mortality, perinatal complications and mortality, prematurity, low birth weight, poor child nutrition, and mental health impacts for adolescent mothers) and contributes to the persistence of intergenerational cycles of poverty and ill health (17).

17. The determinants of adolescent pregnancy are multiple and systemic and must therefore be addressed in a comprehensive and intersectoral manner. Determinants include: *a*) legal or societal acceptance of child marriage; *b*) early sexual initiation; *c*) child sexual abuse or gender-based violence and other forms of violence; *d*) homelessness; *e*) absence of policies on comprehensive sexuality education (CSE); *f*) legal or administrative rules restricting access to contraception and abortion; *g*) geographical, financial, or attitudinal barriers to SRH services; and *h*) unequal gender norms, roles, and relations.

18. Some segments of the population, including girls and adolescents with lower education; those who are poor, rural, indigenous, or Afrodescendant; have fertility rates three to five times higher than national averages, and experience more adverse health consequences stemming from other risk factors—sexual abuse, bullying, and other forms of violence, homelessness, and drug use (21).

19. Indicator *a* of Goal 6 of the plan of action (3) measures the specific fertility rate for adolescents between 15 and 19 years of age in Latin America and the Caribbean, which fell from 66.5% (2010–2015) to 60.7% (2015–2020), representing a 7.47% decrease over a decade, with significant variations between subregions and countries, as well as within countries. Although not all adolescent pregnancies are unintended, they represent a major phenomenon and are a tracer of gender inequality and violations of rights. Each year, an estimated 21 million pregnancies occur in adolescent girls aged 15 to 19 in low- and middle-income countries, almost half of which (10 million) are unplanned; more than a quarter (roughly 5.7 million) end in abortion, most in unsafe conditions (21, 22). The high number of adolescent pregnancies clearly shows that adolescent fertility is not related to reproductive preferences, but rather to risk factors present in situations of vulnerability, as well as barriers to SRH services, particularly contraception (23, 24).

20. There is consensus on the actions needed to reduce unintended adolescent pregnancy: *a*) collect, analyze, and use accurate and up-to-date data on health outcomes, contraceptive use and its determinants, program performance, and adolescent sexuality/fertility to inform laws and policies; *b*) formulate or revise laws and policies to enhance access to comprehensive SRH services and CSE, accompanied by evaluation mechanisms; *c*) implement intersectoral and community strategies with input from adolescents; *d*) develop national SRH strategies for adolescents that include evidence-based and context-specific actions, budgets to fund actions, and progress tracking indicators disaggregated by age and socioeconomic status; *e*) implement strategies with careful monitoring and with the input and expertise of key stakeholders (governmental officers, non-governmental organizations, United Nations agencies, youth organizations and networks, donor organizations, parents, teachers, and community members); and *f*) conduct periodic reviews of programs and compliance with legal and regulatory frameworks (25, 26).

21. Although policies and programs for the prevention of adolescent pregnancy have become more prominent in national health and development agendas over the past decade (27), challenges persist in terms of institutionalizing and scaling up initiatives. Actions with a focus on school, family, and the adolescent population have been implemented, but they lack the necessary continuity or expansion. In some cases, CSE policies and programs and access to long-acting reversible contraceptive methods have not been systematically implemented. CSE empowers people to make free and informed decisions about their bodies, lives, and futures. It also reduces unintended pregnancies and sexually transmitted infections, including human immunodeficiency virus (HIV) infection, and it improves SRH indicators (28, 29).

### *Unsafe abortion*

22. Given its high prevalence, unsafe abortion is a public health problem. Evidence shows that restrictive policies not only fail to reduce the number of abortions, but also prevent them from being performed safely. A global study reported that 87.4% of abortions in 57 countries where abortion is allowed on demand were safe abortions, compared to 25.2% of abortions in 62 countries where abortion is completely prohibited or allowed only in case of risk to life or physical health. There are also geographical, economic, administrative, and attitudinal barriers to access (30, 31).

23. There are diverse regulatory models in the Region, ranging from those that allow abortion on demand within the mixed model framework that recognizes causes at different stages of pregnancy, to those that are highly restrictive and criminalize abortion in all cases. Most countries in Latin America and the Caribbean only allow abortion under specific conditions: threat to life, health risks, fetal unviability, rape, incest, and mental health. The Dominican Republic, Honduras, Nicaragua, and Suriname are the only countries with a total ban. Argentina, Colombia, and Uruguay allow abortion on demand up to 14, 24, and 12 weeks respectively. Cuba is the only country that has completely decriminalized the practice. Abortion on demand is allowed at various gestational stages in six Mexican states, although the country maintains a generally restrictive model with respect to causes. Abortion legislation varies by state in the United States, while Canada has no legal provisions that limit access (32).

24. The right to access comprehensive reproductive health services—including abortion—is rooted in international human rights law. General comment No. 36 of the Human Rights Committee on the right to life states that protecting the right to life of women and other persons with childbearing capacity includes protecting their right to access safe abortion (33). Comprehensive safe abortion care is also one of the interventions included in the guidance for maintaining essential health services published by the World Health Organization (WHO) in 2020 (34).

25. In recent years, following the global trend, Latin America and the Caribbean has seen a 28% decrease in the rate of unintended pregnancies and a 26% increase in unintended pregnancies that ended in abortion, with a range of 9% to 45% depending on the country (35). In 2010–2014, approximately 6.5 million abortions were performed each year

in Latin America and the Caribbean, compared to 4.4 million in 1990–1994. Of those 6.5 million, 4,897,000 were unsafe abortions (387,000 in the Caribbean, 1,070,000 in Central America, and 3,440,000 in South America) (36). In 2015, complications associated with unsafe abortion were estimated to account for 9.9% of all maternal deaths in Latin America and the Caribbean. Some countries have seen a systematic increase in indirect causes of maternal mortality attributable to poor coverage and quality of antenatal care, and lack of access to contraception and safe abortion (37).

26. The Region shows inequalities in access to safe abortion. Girls who are victims of sexual violence, adolescent girls, women living in poverty, persons with disabilities, women living in areas far from large cities, and migrant women have the most difficulty in accessing quality and timely abortion services where they are not legally prohibited. These inequalities stem from various access barriers: *a*) personal and interpersonal (lack of information on the right to abortion and how to access services, late recognition of pregnancy, lack of support, including from a partner); *b*) logistics (distance, mobility, difficulties in leaving household tasks and/or work); *c*) social (stigma and social pressure); and *d*) the health system (availability of services, referral mechanisms, limited clinical options, quality of treatment, and abusive utilization of conscientious objection). There are also barriers resulting from legal and health regulations, such as waiting times, cost of procedures and transfers, and lack of health coverage. Over the past 15 years, countries that have limited their legal restrictions and implemented access policies have seen reduced maternal mortality and morbidity from abortions and unsafe abortions, with most abortions occurring in the first 12 weeks of gestation (30–32).

27. The experience of countries in Latin America and the Caribbean shows a need for legally supported policies to: *a*) improve universal and free access to contraception to prevent unintended pregnancies; *b*) provide quality postabortion services to reduce illness and death associated with unsafe abortion and ensure postabortion contraception; *c*) improve policies to provide access to safe abortion with clinical and self-managed options (including medical abortion); *d*) broaden the basis for legal abortion to reduce unsafe abortions; and *e*) adapt care protocols to WHO recommendations (35–39).

### ***Gender violence***

28. The most recent WHO estimates, from 2021, indicate that 34% of women and girls in the Region of the Americas between 15 and 49 years of age have experienced physical and/or sexual violence from an intimate partner or sexual violence from a non-partner at some point in their lives (40). Data indicate that intimate partner violence is the most common form of violence against women. One in four women in the Region (nearly 53 million women) has experienced physical and/or sexual violence from an intimate partner at least once in her lifetime (41). Violence often begins early (21% of women experience violence from an intimate partner by the time they reach age 25) and does not cease over the life course (28% of women over 65 experience intimate partner violence). Violence has serious consequences for physical, mental, sexual, and reproductive health. Obstetric violence must also be addressed, as it constitutes a violation of rights and has implications for physical and mental health.

29. Evidence shows that violence against women and girls can be prevented and its consequences can be mitigated. The health sector plays a key role, as it has the capacity to detect abuse early and provide survivors with quality care, while working with other government sectors and partners to advance multisectoral action. The COVID-19 pandemic, however, has exacerbated access barriers and gaps in services, hampering the timeliness and quality of care following sexual violence.

30. The countries of the Region have shown progress in producing information on violence against women and girls, including: integrating prevention, care, and redress for violence against women in health policies and plans; developing protocols and guidelines for health system response; training health professionals; and strengthening comprehensive care services following cases of rape. A recent PAHO report shows that 83% of Member States have included this topic in their health plans or policies; 80% of countries have a multisectoral policy for prevention of violence against women or a national gender policy that addresses violence against women in a meaningful way; and 60% have at least one health sector protocol for the prevention of violence against women (42). While the high number of protocols represents a substantial achievement for the Region, more efforts are needed to strengthen document quality, alignment with current evidence, and implementation. The more detailed the guidance, the easier it will be for health workers to understand exactly what is required of them.

### *Cervical cancer*

31. Cervical cancer incidence and mortality have decreased over the past decade in the Region, but in most countries and territories, rates remain above the elimination threshold indicated in the global strategy (4 per 100,000). It is the third most common cancer diagnosis, with considerable variation between countries, and remains the most common one for women in 11 of the 32 countries and territories with available data (43). In 2020, the incidence ranged from 6.1 per 100,000 women in North America, to 13.8 per 100,000 in Central America, and 15.4 per 100,000 in South America (44).

32. Latin America and the Caribbean has the second highest cervical cancer mortality rate worldwide, with the highest rates in the Caribbean (8.2 per 100,000), followed by South America (7.8 per 100,000), and Central America (6.8 per 100,000) (44). Although some countries have promoted legislation for cancer treatment, this does not meet the need for a comprehensive vision encompassing prevention, early detection, access to vaccines and medicines, broad management of information, and funding for catastrophic expenses.

33. Over the past decade, 16 countries in Latin America and the Caribbean have updated their recommendations to introduce new screening tests or alternative programmatic approaches; nevertheless, cytology remains the primary screening test (45). Regarding indicator 3.1.7 of the plan of action (3), which measures the number of countries and territories that have introduced vaccination against the human papillomavirus (HPV) in their vaccination programs, as of 2022 a total of 39 countries and territories had already introduced HPV vaccination programs for girls and 12 had done so for boys (17).



34. Access to cancer drugs, particularly high-cost drugs, remains a challenge, and use of the Regional Revolving Fund for Strategic Public Health Supplies remains limited. Population-level cancer registries are critical for planning, monitoring, and evaluating national actions; however, more than half of countries in Latin America and the Caribbean lack a high-quality registry. Less than 10% of the population is covered (45).

35. Evidence shows that low levels of screening and early detection in vulnerable groups arise from multiple barriers: *a*) structural (socioeconomic status and educational level); *b*) cultural (beliefs and attitudes linked to cervical cancer, discrimination, non-sensitive services, and misinformation and prejudices among service providers); and *c*) systemic issues associated with the health system (lack of access to detection and follow-up due to gaps in available technology, and poor response capacity and organization of health services).

36. During the COVID-19 pandemic, cancer screening services were disrupted, with 17% of countries in Latin America and the Caribbean reporting disruption of at least 50% of services due to diminished care seeking, reallocated health resources, and other factors. The effects of these restrictions have not yet been fully analyzed (46).

### ***Persons with disabilities***

37. Persons with disabilities face considerable health inequalities. Estimates report that almost 12% of the total population of Latin America and the Caribbean (some 66 million people) has at least one disability (47). In SRH, people with disabilities have a long history of being made invisible, misunderstood, and discriminated against, due to incorrect assumptions of non-sexuality, and limited autonomy to decide about their bodies, health, and sexual and reproductive lives.

38. Persons with disabilities deal with additional barriers to accessing SRH services, education, and information, and they face greater exposure to gender-based and other forms of violence and abuse. Barriers include inaccessible health spaces, communication difficulties, lack of specific training for health professionals, and financial limitations. The Convention on the Rights of Persons with Disabilities recognizes these people as subjects of law, implying full recognition as sexual beings, with functional diversity, different ways of living sexuality proactively, and the ability to decide for themselves.

39. The Region has made progress toward achieving the goals stated in the final report of the PAHO Plan of Action on Disabilities and Rehabilitation (48). More countries added national disability legislation and plans, although many of these have not been fully implemented and persons with disabilities in many countries continue to face significant barriers to health care services (49).

***LGBT population***

40. Despite limited data on morbidity, mortality, and access to health services among the LGBT population, research and epidemiological information indicate that they have worse health outcomes than the heterosexual population. They also face barriers to patient-centered health care and are often unable to make early and timely use of health services, or any use at all. LGBT people living with HIV who experience high levels of stigma have been found to be 2.4 times more likely to delay seeking medical care and have greater mental health problems. Other SRH issues include difficulty in starting a family, lack of cancer screening, low visibility in CSE, and increased risk of violence (including child sexual abuse) (50).

41. The access barriers to health care faced by the LGBT population stem from stigma and discrimination in society, including from health systems. This results in inadequate understanding of their specific problems, denial of care, insufficient or below-average care, and prejudices about the causes of illnesses. Members of this population are fearful about a lack of guarantees regarding their confidentiality and privacy. The absence of laws and policies on discrimination against this population group hinders access to health services. Other obstacles include the shortage of LGBT-sensitive services, little specific training for health providers, and a dearth of protocols and standards for the care of each group within the LGBT collective. Moreover, a large part of this population also has low financial capacity and limited resources (51).

***Men's health***

42. Gender analysis shows more premature mortality among men than women. Male gender roles and socially imposed practices affect many aspects of health, with risk behaviors (lifestyles and conduct) that lead to men making greater use of health services in emergencies (presenting uncontrolled chronic conditions, and injuries due to external causes) and underutilizing prevention and control services. Inadequate self-care of physical and mental health negatively affects the life trajectories of many men.

43. Discrepancies between men's health needs and their social behaviors should be addressed through comprehensive and integrated policies that are sensitive and that promote gender co-responsibility. The health system deals with the consequences of hegemonic and fragmented male socialization. With regard to SRH specifically, the prevalence of a gender culture that perceives reproduction as an exclusively female phenomenon means that men are not called upon to assume comprehensive responsibility in prenatal care, childbirth, breastfeeding, child care, and domestic activities. Although it is true that some solutions to these problems are emerging from civil society and the academic sector, organized programmatic responses are insufficient, incomprehensive, and unconnected to other sectors of public policy.

**Action Needed to Improve the Situation**

44. To expand access to sexual and reproductive health services, reduce inequities, ensure human rights, and advance universal coverage, the following measures are submitted for consideration by Member States:

- a) Promote and implement comprehensive normative frameworks, policies, and regulations that guarantee the exercise of sexual and reproductive rights and universal access to SRH services, without discrimination of any kind, to reduce inequities, improve development opportunities for individuals and families, and progress toward effective fulfillment of commitments in this area.
- b) Expand access to SRH services with a primary health care approach, through:
  - i. Capacity and effectiveness at the first level of care in integrated health networks, ensuring comprehensive SRH services with an inclusive approach to health, sexuality, and reproduction.
  - ii. Community participation and intersectoral collaboration to reach vulnerable groups.
  - iii. Training for health teams from the perspective of equity, gender, and the right to comprehensive SRH care.
  - iv. Restoration of essential SRH services affected during the COVID-19 pandemic.
  - v. Implementation of the task-sharing care model to expand the availability and accessibility of services and digital health innovations.
- c) Increase investment in SRH policies and programs, with significant economic benefits for governments, societies, and individuals. Ensure adequate and sustainable funding to implement cost-effective evidence-based interventions, organize and deliver comprehensive SRH services, and provide access to universal and free SRH medicines.
- d) Strengthen collaboration, intersectoral work, and care protocols between the areas of health, education, social protection, security, and justice to enact comprehensive policies and programs that allow action on SRH determinants and that respond to violations of sexual and reproductive rights, with particular emphasis on comprehensive sexuality education.
- e) Strengthen research and information systems to collect and analyze data on SRH indicators disaggregated by age, gender (including LGBT diversity), ethnic-racial affiliation, and place of residence to identify equity gaps and inform the monitoring and evaluation of SRH policies and programs, as well as local evidence needed to contextualize actions, under a legal framework that integrates and protects data.
- f) Increase political commitment to improve the coverage and effectiveness of SRH policies and programs, establishing short- and medium-term goals, accountability mechanisms, and spaces for affected groups to participate.

**Action by the Executive Committee**

45. The Executive Committee is invited to take note of this report and provide any comments it deems pertinent.

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