

Ensure Access to Comprehensive Health Services

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OVERVIEW

While many countries continue to face daunting obstacles to realizing access to health services for all girls and women, there are demonstrated strategies that can help them break down these barriers. This brief discusses some of the solutions that can help communities ensure that girls and women have access to a comprehensive range of services promoting their right to physical and mental health. Included among these solutions are: implementing women-centered care; integrating service delivery; optimizing the health workforce; innovating health financing through Universal Health Coverage, and boosting the prevention of non-communicable diseases. Importantly, women and girls should be involved in the design, implementation, evaluation and accountability of policies, programs and services.

SECTION 1: FRAMING THE ISSUE

Every year, one billion people do not receive the health services they need, while 150 million people face financial catastrophe, and another 100 million are impoverished by the costs of healthcare.^{1,2} While treatment is becoming more accessible for certain diseases, and in a growing number of geographical contexts, it remains unaffordable and inaccessible for many. With respect to the growing burden of non-communicable diseases (NCDs), including chronic illnesses such as diabetes and cancer, that progress slowly over long periods of time, access to adequate healthcare is often beyond reach.^{3,4}

Access to mental healthcare is equally critical to ensuring the wellbeing of girls and women. Mental health warrants prioritization on a global scale, underscored by the fact that suicide is now the second leading cause of death among people age 15-29;⁵ and for adolescent girls, it is the leading cause of death.⁶ Sexual and reproductive health issues, such as unwanted pregnancy, gender-based violence, and discrimination based on sexual orientation or gender identity, are among the factors which can contribute to poor mental health.⁷

Out-of-pocket spending on healthcare, combined with indirect costs such as transport, is a fundamental barrier to care for many, but particularly for girls and women.⁸ In some cultures, women have limited access to household resources, restricted mobility, or may be prevented from making decisions about their own care.⁹ Furthermore, women who lack adequate prenatal care, maternal care, and reproductive health services during their childbearing years risk complications not only to their own health, but to the health of their families, communities, and future generations.¹⁰

➔ *For more, please reference the brief focused on respecting, Protecting, and Fulfilling Sexual Health and Rights.*

In order to respond to the needs of girls and women throughout their life cycle, health systems must provide services across a women-centered continuum of care. In 2015, the World Health Organization released a global strategy that called for a shift in the design of health systems toward a more integrated, people-centered approach.¹¹ Building off this strategy, women-centered care should focus on the context and health needs of girls and women from infancy to old age, emphasizing patient empowerment and strong relationships with healthcare providers.

Given the increasing burden of non-communicable diseases, providing a continuum of care that can address ongoing, chronic illnesses is the only practical and effective approach to take. NCD-related deaths — including illnesses that target women, such as breast and cervical cancer — are projected to increase from 38 million in 2012 to 52 million by 2030.^{12,13} For instance, more than 85% of cases and deaths from cervical cancer occur in low- and middle-income countries.¹⁴ Between 2008 and 2012, breast cancer incidence rose by 20% worldwide, while mortality rose 14%.¹⁵ NCDs — particularly cardiovascular disease, cancers, respiratory diseases, and diabetes — are leading killers of women, accounting for some 65% of all female deaths in 2008.^{16,17}



Ensuring access to comprehensive healthcare for girls and women is linked to the achievement of several of the Sustainable Development Goals (SDGs) and targets, including:

SDG 1: End poverty in all its forms everywhere

- **1.3** Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable

SDG 3: Ensure healthy lives and promote wellbeing for all at all ages

- **3.1** Reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- **3.2** End preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births
- **3.3** End the epidemics of AIDS, tuberculosis, malaria, and neglected tropical diseases and combat hepatitis, water-borne diseases, and other communicable diseases
- **3.4** Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
- **3.7** Ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- **3.8** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all

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SECTION 2: SOLUTIONS AND INTERVENTIONS

While communities and countries face unique obstacles to achieving access to health services for all girls and women, there are demonstrated strategies that can help realize this goal:

- Implement people-centered care, with a focus on women
- Increase investments in integrated healthcare services
- Optimize health workforce resources to enhance continuity of care
- Innovate health financing through Universal Health Coverage
- Maintain health information with life-long individual medical records, ideally patient-held
- Ensure medical products and technologies are accessible
- Ensure prevention, screening, and treatment options for non-communicable diseases

Implement People-Centered Care, with a Focus on Women¹

The needs of girls and women must be prioritized across all levels of the health system and they must be involved in this process to ensure that their perspectives and priorities are considered. The table below shows the key characteristics of conventional vs. women-centered care.

	CONVENTIONAL CARE	WOMAN-CENTERED CARE
Focus	Illness and cure	Health needs, including prevention, episodic care, and chronic care
Relationship between women and providers/system	Limited to the consultation	Enduring throughout the life-cycle
Nature of care	Episodic, curative care	Comprehensive, continuous, and client-centered
Responsibility of provider/system	Effective and safe advice during consultation	The health of women in the community throughout their life; consideration of the social determinants of health
Role of women	Consumers of care	Partners in managing their own health and the health of those in the community

[Table adapted from report of WHO meeting on People-Centered Care in Low- and Middle-Income Countries held 5 May 2010.]

¹ For the duration of this brief, people-centered care with a focus on women will be referred to as women-centered care.

Increase Investments in Integrated Healthcare Services

There are many strategies to integrating health service delivery. These include training providers to offer various services, placing multiple services at the same facility, and providing referrals as needed among service providers.¹⁹ Integration is not about offering all possible services in a single package. Rather, it should consider the local epidemiological context. For example, as the onset of diabetes during pregnancy is associated with a range of risks to maternal and newborn health, integration of service delivery and care coordination is crucial, particularly in countries with a high burden of diabetes.^{20, 21}

Integration also makes sense from the patient perspective. The ability to receive multiple services from a single provider, or at the same site, reduces travel time and increases the likelihood that girls and women will seek out these services.²² And where treatment of stigmatized diseases, such as HIV, is integrated with other services, concerns about disclosure are reduced.^{23, 24, 25}

Case Study: DREAMS project aims for an AIDS-free generation

The DREAMS project aims for an AIDS-free generation. Across sub-Saharan Africa, girls and young women make up 71% of new HIV infections among the adolescent population. Launched in February 2016, the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) partnership aims to reduce the high incidence of HIV infections among girls and young women in ten countries (Kenya, Lesotho, Malawi, Mozambique, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe) through integrated efforts. DREAMS' holistic approach includes a core package inclusive of health and issues outside of the health sector and addresses the structural drivers that impact HIV risk in girls, such as poverty, gender inequality, sexual violence, and education. The following six areas serve as a focus for the project: strengthening capacity for service delivery; keeping girls in secondary school; linking men to services; supporting pre-exposure prophylaxis; providing a bridge to employment; and applying data to increase impact.²⁶



- **3.b** Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all
- **3.c** Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States
- **3.d** Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

SDG 5: Achieve gender equality and empower all women and girls

- **5.1** End all forms of discrimination against all women and girls everywhere
- **5.2** Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual, and other types of exploitation
- **5.6** Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences



Optimize Health Workforce Resources to Enhance Both the Continuum and Continuity of Care

To ensure that women, youth, and adolescents receive comprehensive and timely care, the continuum and continuity of care should be based upon a system of referrals and coordination among community-based providers, primary care clinics, first-level hospitals, and referral hospitals. To realize this goal, the lack of skilled medical professionals must be addressed at every level of the system. To maximize operational efficiency, task shifting and task sharing — whereby less-credentialed providers are trained to manage specific tasks — can help to close the human resources gap. Such strategies are endorsed by WHO and implemented in a number of low- and middle-income countries (LMICs) to deliver HIV-related services and essential interventions for maternal and newborn health.^{27,28}

Task shifting and sharing can involve a range of mid-level and lay health workers, including non-physician clinicians, nurses, midwives, and community health workers. Specific models take into consideration the local health workforce, disease burden, and existing gaps in service delivery. Such innovative responses to the shortage of human resources have substantial potential to improve women's access to health services. In the case of non-communicable diseases, non-physician health workers have been shown to successfully detect and manage chronic conditions.²⁹ The evidence on the involvement of community health workers in NCD prevention and control is promising, but must be expanded.^{30,31}

Case Study: WHO Essential Intrapartum and Newborn Care in the Philippines

The WHO Philippines Country Office helped to develop an urgently needed Essential Intrapartum and Newborn Care (EINC) package.³² From this effort, the very successful program, *Unang Yakap*, or “First Embrace” emerged, referring to the immediate and uninterrupted skin-to-skin contact between mothers and newborns that fosters a successful start to breastfeeding.³³ The full package is based upon hospital reform initiatives, model centres of excellence, education reforms and social marketing.³⁴ Within one year, 16 000 doctors, nurses, midwives and other health workers were trained in roughly 50 centers through capacity-building initiatives throughout the country.³⁵ Results of this program boasted healthier newborns, increased satisfaction from mothers, and overall facility cost savings.³⁶

Innovate Health Financing Through Universal Health Coverage

Increasingly, countries are building momentum towards improving access to Universal Health Coverage (UHC) to provide quality health services that are equitable and affordable for all. A growing body of evidence calls for a combination of clinical interventions and outreach that builds awareness of healthy lifestyles and encourages their adoption.^{37,38}

Universal Health Coverage seeks to provide services for all while protecting patients from financial hardship.³⁹ More than 100 low- and middle-income countries (LMICs), home to three-quarters of the world's population, have taken steps to pursue UHC.⁴⁰ While no unifying blueprint exists, core guiding principles based on country experiences include:

- **Increasing funds:** Governments have successfully combined funds from different sources — with compulsory contributions (often sourced from consumption taxes) as a key mechanism to increase the amount of pooled capital.^{41,42,43,44}
- **Pooling resources across the population:** This allows the redistribution of resources from the wealthy to the poor and from the healthy to the sick.^{45,46,47} Pooling schemes should be integrated and draw across income and social groups, including women and low-income populations. Schemes that are fragmented may leave women behind. For example, social health insurance that covers the formal workforce may exclude women, who are more highly engaged in the informal economy.⁴⁸
- **Strategically designing benefits packages:** Although the benefits packages may vary, they should respond to the needs of women and low-income populations.

Reviews suggest that comprehensive UHC schemes in LMICs, inclusive of the full range of sexual and reproductive health services, have a positive effect on access and use of health services, as well as on financial protection (as measured by out-of-pocket expenditures), especially when targeting low-income populations.^{49,50,51} For example, eliminating fees for maternal health services leading to has often led to increases in skilled deliveries and caesarian sections at public health facilities.^{52,53} However, appropriate measures need to be taken to offset the loss of revenue and respond to the increased demand for services.

Maintain Health Information with Life-Long Individual Medical Records, Ideally Patient-Held

Individual medical records are the backbone of comprehensive care for women. They are important tools for planning and managing care coordination, documenting history, and monitoring progress so as to understand the health needs of girls and women throughout their lives. The confidential aggregation of data from individual records also provides information that can be used to guide forecasting, supply planning, resource allocation, and evaluation.⁵⁴ Individual records are needed to permit continuity of information across encounters with the health system over services, time, and distance; they are also necessary for accurate reporting.⁵⁵



SDG 9: Build resilient infrastructure, promote inclusive and sustainable industrialization and foster innovation

- **9.1** Develop quality, reliable, sustainable and resilient infrastructure, including regional and transborder infrastructure, to support economic development and human well-being, with a focus on affordable and equitable access for all

SDG 11: Make cities and human settlement inclusive, safe, resilient and sustainable

- **11.2** By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities, and older persons

International agreements related to improving maternal and newborn health and nutrition include:

- Declaration of Alma-Ata, International Conference on Primary Health Care (1978)
- The 1979 Convention on the Elimination of All Forms of Discrimination against Women (Articles 11 (1) (f), 12 and 14 (2) (b))
- The 1989 Convention on the Rights of the Child (Article 24)
- The Committee on Economic, Social and Cultural Rights, general comment N° 14 on the right to the highest attainable standard of health (2000)
- The UN General Assembly of September 2011 released Political Declaration on NCDs
- The UN Resolution on Universal Health Coverage (2012)
- The WHO launched the Global action plan for the prevention and control of NCDs (2013–2020)
- Sustainable Development Goals (SDGs) (2015–2030)



Another innovative strategy, originally driven by HIV and TB programs, is the use of electronic medical record systems.⁵⁶ The World Health Organization has published a reference manual outlining considerations needed to introduce such systems, including educating staff, computer literacy, funding for infrastructure, data security, and quality assurance.⁵⁷ One purported advantage of electronic medical records is that they are generally more efficient or accurate than paper-based systems when large numbers of patients are involved.^{58, 59} Some studies have shown that they can also support the chronic clinical management of HIV and TB patients.⁶⁰

Ensure Medical Products and Technologies are Accessible

Equitable access to comprehensive health services requires the availability of essential medicines, vaccines, and technologies. In reality, some medicines are chronically unavailable in low- and middle-income countries as a result of countries failing to include medicines on the essential drug list,⁶¹ inefficiencies in procurement and distribution systems, and unnecessarily high prices.⁶²

Countries should implement the framework recommended by the WHO to ensure equitable access to high quality, safe, and cost-effective medicines.⁶³ It includes the following components:

- **Rational selection of medicines:** Countries must develop active purchasing based on the costs and benefits of alternatives.⁶⁴
- **Affordable pricing:** Governments should ensure transparency in purchasing and tenders by monitoring and publicizing medicine prices.⁶⁵ Policies that support the purchase of generic drugs (the norm for HIV/AIDS) should be extended to NCDs.⁶⁶
- **Remove taxes and duties:** Countries should use their negotiating power to control mark-up, addressing excessive taxes and duties on medicines.⁶⁷
- **Universal Health Coverage and sustainable financing:** Governments should seek private-sector partners willing to embrace a social business model, whereby firms seek to maximize social profit while making financial profit to cover their costs and provide returns to their owners.⁶⁸
- **Reliable health and supply systems:** Governments need to team with commercial partners and apply modern business techniques to optimize the efficiency and reliability of drug distribution systems. This includes a greater application of supply-chain optimization analysis, a technique commonly applied in the private sector to manage distribution.⁶⁹

Case Study: Social Business Initiatives to Improve Access to Essential Drugs in Kenya

Governments are increasing their partnerships with drug manufacturers for mutual gain. These alliances, known as social business interventions, pair commercial partners with governments or non-profit organizations. In 2012, the Government of Kenya teamed with a pharmaceutical industry partner, Novartis, to launch the Familia Nawiri program to increase access to essential drugs for otherwise under-treated conditions (including hypertension and diabetes) in the poorest communities.⁷⁰ Community health educators, often women, played a pivotal role in community engagement and linking community members with healthcare providers for care and access to medicines.⁷¹

Ensure Prevention, Screening and Treatment Options for Non-Communicable Diseases

Improving mechanisms for prevention, screening and treatment of NCDs is critical to achieving better health outcomes.⁷² For example, addressing gestational diabetes through prevention, universal early screening, post-partum screening, treatment, and management will not only improve maternal and newborn health but also help to prevent the onset of type 2 diabetes and other associated NCDs in women, their babies, and subsequent generations.⁷³ On the prevention side, achieving reductions in the four primary risk factors that are common to the top NCDs — tobacco use, physical inactivity, alcohol abuse, and poor diet — is a cornerstone of the Global NCD action plan.⁷⁴ Malnutrition is also a concern. Children born to malnourished women, or to women at risk of or diagnosed with gestational diabetes, are more likely to develop chronic illnesses such as diabetes or heart disease as they grow older.⁷⁵

Governments play an important role in promoting healthy behaviors through policies and tools — within and outside of the traditional health sector.^{76, 77} Toward this end, the WHO and the Lancet Commission on Investing in Health recommend high-priority, cost-effective, and achievable interventions such as taxation, regulation, and legislation.^{78, 79} For example, many studies show that taxing tobacco reduces its use and can prevent deaths, while also raising revenue.^{80, 81} Taxation on alcohol and sugar-sweetened beverages can provide similar benefits.^{82, 83, 84} Yet the implementation of these measures remains uneven. Of the 178 countries that completed the 2013 NCD country capacity assessment survey, 85% reported taxes on tobacco and 76% on alcohol, whereas only 11% had fiscal policies on foods and non-alcoholic beverages with a high sugar content.⁸⁵

Involving girls and women as partners in the management of their health, and as agents of change within their communities, is essential not only to prevention, screening, and treatment efforts, but a fundamental aspect of women-centered care. As women often make decisions that directly affect diet in their households, they are also uniquely positioned to help tackle the NCD crisis in their families and communities.⁸⁶ Women and girls need to be equipped with better information about NCD risk factors and the health consequences of their lifestyle choices. Girls' and women's involvement in sport is one way to foster wellbeing and healthy behaviors.⁸⁷

Case Study: ASHA - Women as Community Health Workers in India

India's National Rural Health Mission was launched in 2005, aiming to provide every village in the country with a trained female community health activist Accredited Social Health Activist (ASHA).⁸⁸ ASHAs serve as a link between their own community and the public health system. As community health activists, ASHAs provide prevention education on a range of health issues, including reproductive and sexual health, and healthy lifestyles to prevent diabetes and other NCDs.⁸⁹

Case Study: Promoting Physical Activity Among Women in Tonga

The Ministry of Health and the Ministry of Internal Affairs in Tonga sponsored a campaign to combat sedentariness and obesity among girls and women.⁹⁰ In partnership with the Tonga Netball Association (and support from the Australian Sports Outreach Program),⁹¹ the campaign — Kau Mai Tonga: Netipol (Come on Tonga, let's play netball!) — used netball as a means of encouraging activity.⁹² Guided by the Tonga National Strategy to Prevent and Control Non-Communicable Diseases (2010–2015),⁹³ the campaign employs community mobilization, large-scale advertising, communication, and interpersonal education.⁹⁴ Since the launch in 2012,⁹⁵ the participation of women in the sport has increased (with more than 560 registered netball clubs) and the participants know more about the benefits of physical activity.⁹⁶



SECTION 3: THE BENEFITS OF INVESTMENT

There are multiple benefits to building health systems that provide a continuum of care for girls and women. First and foremost, it saves lives and, subsequently, money. Scaling up the full package of clinical and outreach interventions for NCDs to 80% coverage across 42 low-and middle-income countries, which account for 90% of the global NCD burden, would cost US \$11.4 billion annually from 2011 to 2025 – this equals an annual cost of US\$ 1 per person in low-income countries, US\$ 1.50 in low-and middle-income, and US\$ 3 in upper middle-income countries.⁹⁷

Investing in prevention and screening helps reduce health risks and costs. Evidence shows that vaccinating girls against the human papilloma virus (HPV) over the next 10 years – a cost of only \$10 to \$25 per person – would avert more than 3 million deaths from cervical cancer across 72 low-and middle-income countries.⁹⁸ Additionally, screening vaccinated women for cervical cancer just three times in their lifetime would reduce mortality by another 20-25%.⁹⁹

Furthermore, the moral and economic costs of failing to invest in integrated health systems are staggering. In the absence of new interventions, the cumulative economic loss to low-and middle-income countries from the four main NCDs – cardiovascular disease, cancers, respiratory diseases, and diabetes – is estimated to be more than US \$7 trillion between 2011 and 2025. On average, the economic burden of these NCDs amounts to an annual loss per person of US \$25 in low-income countries, US \$50 in low-and middle-income countries, and US \$139 in upper middle-income countries.¹⁰⁰

Undetected or untreated, NCDs, including mental illnesses, cause severe complications, disability, and premature death; they can affect productivity, increase financial hardship, burden health systems, and hinder economic growth. For example, reducing the mortality from ischemic heart disease and strokes by 10% has the potential to reduce economic losses in low-and middle-income countries by US\$25 billion each year.¹⁰¹ The international community needs to act now to curb the NCD crisis, especially for girls and women who suffer inequities in accessing the health services they need.

SECTION 4: CALLS TO ACTION

Governments bear the greatest responsibility to ensure that girls and women have access to comprehensive healthcare, but everyone has a role to play to reduce barriers to integrated services that promote the health and wellbeing of all.

In order to power progress for all, many different constituents must work together – governments, civil society, academia, media, affected populations, the United Nations, and the private sector – to take the following actions for girls and women:

- Eliminate legal, financial, social, and institutional barriers that prevent access to comprehensive health services for girls and women, including age of consent for accessing services.
(Most relevant for: governments)
- Set and meet national targets across girls' and women's health and wellbeing needs – including sexual and reproductive health, as well as communicable and non-communicable diseases.
(Most relevant for: governments)
- Maintain accessible health information with life-long individual medical records.
(Most relevant for: governments and the private sector)
- Promote girls' and women's involvement in sport as a critical way to foster wellbeing and healthy behaviors.
(Most relevant for: governments, civil society, the United Nations, and the private sector)
- Focus efforts towards more integrated, woman-centered healthcare to address the needs of girls and women along the lifecycle.
(Most relevant for: governments, civil society, the United Nations, and the private sector)
- Build the capacity of health workers and address health worker shortages, particularly in rural and underserved areas.
(Most relevant for: governments, civil society, the United Nations, and the private sector)
- Build and disseminate evidence of the impact of woman-centered care.
(Most relevant for: governments, civil society, academia, media, affected populations, the United Nations, and the private sector)

ENDNOTES

- ¹ Distler, Rebecca and Erisa Scalera. "500+ Organizations Launch Global Coalition to Accelerate Access to Universal Health Coverage." The Rockefeller Foundation. Geneva: World Health Organization, 2014. Web. <http://www.who.int/universal_health_coverage/universal-health-coverage-access-pr-20141212.pdf?ua=1>.
- ² Evans, David B, Riku Elovainio, and Gary Humphreys. "Health systems financing: the path to universal coverage." The World Health Report. Geneva: World Health Organization, 2010. Web. <http://apps.who.int/iris/bitstream/10665/44371/1/9789241564021_eng.pdf>.
- ³ Knaul, Felicia Marie, et al. "Achieving Effective Universal Health Coverage And Diagonal Approaches To Care For Chronic Illnesses." Health Affairs 34.9 (2015): 1514-1522. Web. <<http://content.healthaffairs.org/content/34/9/1514.abstract>>.
- ⁴ "NONCOMMUNICABLE DISEASES: A PRIORITY FOR WOMEN'S HEALTH AND DEVELOPMENT." 2011. Web. <http://www.who.int/pmnch/topics/maternal/2011_women_ncd_report.pdf.pdf>.
- ⁵ "Preventing suicide: a global imperative." Geneva: World Health Organization, 2014. Web. <http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1&ua=1>.
- ⁶ "Health for the World's Adolescents: A second chance in the second decade." Geneva: World Health Organization, 2014. Web. <http://apps.who.int/adolescent/second-decade/files/1612_MNCAH_HWA_Executive_Summary.pdf>.
- ⁷ "Defining Sexual Health Report of a technical consultation on sexual health 28–31 January 2002" Geneva: World Health Organization, 2002. Web. <http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf>.
- ⁸ "Insights from 10,000 Women on the Impact of NCDs." 2013. Web. <<http://arogyaworld.org/wp-content/uploads/2014/12/Arogya-Full-Report-For-Web.pdf>>.
- ⁹ Ibid.
- ¹⁰ "Universal Access to Reproductive Health: Progress and Challenges. UNFPA. 2016. Web. <http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_Reproductive_Paper_20160120_online.pdf>.
- ¹¹ "WHO global strategy on people-centred and integrated health services." Interim Report. Geneva: World Health Organization, 2015. Web.
- ¹² "NCD mortality and morbidity." n.d. Web. 22 Mar. 2016. <http://www.who.int/gho/ncd/mortality_morbidity/en/>.
- ¹³ "Projections of mortality and causes of death, 2015 and 2030." Jul. 2013. World Health Organization. Web. 22 Mar. 2016. <http://www.who.int/healthinfo/global_burden_disease/projections/en/>.
- ¹⁴ Jemal, Ahmedin, et al. "Global Cancer Statistics." CA: A Cancer Journal for Clinicians 61.2 (2011): 69–90. Web. 1 Mar. 2016.
- ¹⁵ "Latest world cancer statistics: Global cancer burden rises to 14.1 million new cases in 2012: Marked increase in breast cancers must be addressed." Press Release. International Agency for Research on Cancer (IARC). Geneva: World Health Organization, 2013. Web. 1 Mar. 2016. <http://www.iarc.fr/en/media-centre/pr/2013/pdfs/pr223_E.pdf>.
- ¹⁶ "Global status report on noncommunicable diseases 2014." Geneva: World Health Organization, 2014. Web. <http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1>.
- ¹⁷ "NONCOMMUNICABLE DISEASES: A PRIORITY FOR WOMEN'S HEALTH AND DEVELOPMENT." 2011. Web. <http://www.who.int/pmnch/topics/maternal/2011_women_ncd_report.pdf.pdf>.



- 18 "People-centred care in low- and middle-income countries." Geneva: World Health Organization, 2010. Web. <<http://www.personcenteredmedicine.org/doc/genevathree/geneva2011i.pdf>>.
- 19 "WHO Global Strategy on People-Centered and Integrated Health Services: Interim Report." World Health Organization, 2015. Web. <http://apps.who.int/iris/bitstream/10665/155002/1/WHO_HIS_SDS_2015.6_eng.pdf?ua=1&ua=1>
- 20 Gounder, C. R. and R. E. Chaisson. "A diagonal approach to building primary healthcare systems in resource-limited settings: women-centred integration of HIV/AIDS, tuberculosis, malaria, MCH and NCD initiatives." *Tropical Medicine & International Health* 17.12 (2012): 1426–1431. Web. <<http://onlinelibrary.wiley.com/doi/10.1111/j.1365-3156.2012.03100.x/full>>.
- 21 Azenha, Gustavo S, et al. "Recommendations towards an integrated, life-course approach to women's health in the post-2015 agenda." *Bull World Health Organ* 91 (2013): 704–706. Web. 22 Mar. 2016. <<http://www.who.int/bulletin/volumes/91/9/BLT.13.117622.pdf>>.
- 22 Winestone, Lena E., et al. "Acceptability and feasibility of integration of HIV care services into antenatal clinics in rural Kenya: A qualitative provider interview study." *Glob Public Health* 7.2 (2012): 149–163. Web. <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3493571/>>.
- 23 Ibid.
- 24 van den Akker, T., et al. "HIV care need not hamper maternity care: a descriptive analysis of integration of services in rural Malawi." *BJOG: An International Journal of Obstetrics & Gynaecology* 119.4 (2012): 431–438. Web. <<http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2011.03229.x/full>>.
- 25 Topp, Stephanie M., et al. "Strengthening Health Systems at Facility-Level: Feasibility of Integrating Antiretroviral Therapy into Primary HealthCare Services in Lusaka, Zambia." *PLoS One* 5.7 (2010). Web. <<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0011522>>.
- 26 "DREAMS innovation challenge: Innovating for an AIDS-free future for girls and women." 2016. Web. <<http://www.pepfar.gov/documents/organization/247602.pdf>>.
- 27 "Addis Ababa Declaration." Paper presented at the International Conference on Task Shifting. Geneva: World Health Organization, 2008. Web. <http://www.who.int/healthsystems/task_shifting/Addis_Declaration_EN.pdf?ua=1>.
- 28 "WHO recommendations: optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting." Geneva: World Health Organization, 2012. Web. <http://apps.who.int/iris/bitstream/10665/77764/1/9789241504843_eng.pdf>.
- 29 Joshi, R., et al. "Task Shifting for Non-Communicable Disease Management in Low and Middle Income Countries – A Systematic Review." *PLoS One* 9.8 (2014). Web. <<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0103754>>.
- 30 Jafar, Tazeen H., et al. "Community based lifestyle intervention for blood pressure reduction in children and young adults in developing country: cluster randomised controlled trial." *BMJ* 340 (2010). Web. <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2881949/>>.
- 31 Neupane, D., et al. "Community health workers for non-communicable diseases." *Lancet Glob Health* 2.10 (2014). Web. <[http://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(14\)70303-1/fulltext?rss=yes](http://www.thelancet.com/journals/langlo/article/PIIS2214-109X(14)70303-1/fulltext?rss=yes)>.
- 32 "The Work of the World Health Organization in the Philippines January – December 2011." REPORT OF THE WHO REPRESENTATIVE. Geneva: World Health Organization, 2012. Web. <http://www.wpro.who.int/philippines/about/who_philippines_2011_annual_report.pdf?ua=1>.
- 33 Ibid.
- 34 Ibid.
- 35 Ibid.
- 36 Ibid.
- 37 Jamison, Dean T., et al. "Global health 2035: a world converging within a generation." *The Lancet* 382.9908 (2013): 1898–1955. Web. <[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)62105-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62105-4/fulltext)>.
- 38 "Scaling up action against noncommunicable diseases: how much will it cost?" Geneva: World Health Organization, 2011. Web. <http://apps.who.int/iris/bitstream/10665/44706/1/9789241502313_eng.pdf>.
- 39 "Universal Health Coverage Day - GLOBAL PARTNERS." 2015. Web. <<http://universalhealthcoverageday.org/partners>>.
- 40 "Tracking universal health coverage: first global monitoring report." Geneva: World Health Organization, 2015. Web. <http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf?ua=1>.
- 41 Giedion, U., E. A. Alfonso, and Y. Diaz. "The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence." UNICO Studies Series No. 25. Washington: The World Bank, 2013. Web. <http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/02/14/000333037_20130214125444/Rendered/PDF/753260NWPOBox30ewofExistingEvidence.pdf>.
- 42 Kutzin, Joseph. "Anything goes on the path to universal health coverage? No." *Bulletin of the World Health Organization* 90.11 (2012): 867–868. Web. <<http://www.who.int/bulletin/volumes/90/11/12-113654/en/>>.
- 43 Lagomarsino, Gina. "Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia." *The Lancet* 380.9845 (2012): 933–943. Web. <[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)61147-7/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61147-7/fulltext)>.
- 44 Evans, David B, Riku Elovainio, and Gary Humphreys. "Health systems financing: the path to universal coverage." *The World Health Report*. Geneva: World Health Organization, 2010. Web. <http://apps.who.int/iris/bitstream/10665/44371/1/9789241564021_eng.pdf>.
- 45 Kutzin, Joseph. "Anything goes on the path to universal health coverage? No." *Bulletin of the World Health Organization* 90.11 (2012): 867–868. Web. <<http://www.who.int/bulletin/volumes/90/11/12-113654/en/>>.
- 46 Brearley, Lara, Robert Marten, and Thomas O'Connell. "Universal Health Coverage: A Commitment to Close the Gap." London: Rockefeller Foundation, UNICEF, and the World Health Organization, 2013. Web. <http://www.savethechildren.org.uk/sites/default/files/images/Universal_health_coverage.pdf>.
- 47 Evans, David B, Riku Elovainio, and Gary Humphreys. "Health systems financing: the path to universal coverage." *The World Health Report*. Geneva: World Health Organization, 2010. Web. <http://apps.who.int/iris/bitstream/10665/44371/1/9789241564021_eng.pdf>.
- 48 Ravindran, TK Sundari. "Universal access: making health systems work for women." *BMC Public Health* 12 Suppl 1.S4 (2012). Web. <<http://bmcpubhealth.biomedcentral.com/articles/10.1186/1471-2458-12-S1-S4>>.
- 49 Giedion, U., E. A. Alfonso, and Y. Diaz. "The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence." UNICO Studies Series No. 25. Washington: The World Bank, 2013. Web. <http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/02/14/000333037_20130214125444/Rendered/PDF/753260NWPOBox30ewofExistingEvidence.pdf>.
- 50 Moreno-Serra, R. and P. C. Smith. "Does progress toward universal health coverage improve population health?" *The Lancet* 380.9845 (2012): 917–923. Web. <https://www.ucdmc.ucdavis.edu/iph/Committees/MPAC/resources/UniversalHealthcareCoverageandPopulationHealth_Lancet_2012.pdf>.
- 51 "IPPF Calls for G7 leaders to prioritize the full range of sexual and reproductive health services in Universal Health Coverage." 2016. Web. <<http://www.ippf.org/news/IPPF-calls-G7-leaders-prioritize-full-range-sexual-and-reproductive-health-care-services-UNiver>>.
- 52 McPake, B., et al. "Removing user fees: learning from international experience to support the process." *Health Policy Plan*. 26 Suppl 2 (2011): ii104–117. Web. <http://heapol.oxfordjournals.org/content/26/suppl_2/ii104.full>.
- 53 Witter, Sophie, et al. "The national free delivery and caesarean policy in Senegal: evaluating process and outcomes." *Health Policy Plan*. 25.5 (2010): 384–392. Web. <<http://heapol.oxfordjournals.org/content/25/5/384.long>>.
- 54 Mate, Kedar S., et al. "Challenges for routine health system data management in a large public programme to prevent mother-to-child HIV transmission in South Africa." *PLoS One* 4.5 (2009). Web. <<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0005483>>.
- 55 Ibid.
- 56 Fraser, H. S. F. and J. Blaya. "Implementing medical information systems in developing countries, what works and what doesn't." *AMIA Annu Symp Proc*. (2010): 232–236. Web. <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3041413/>>.
- 57 Electronic Health Records: Manual for Developing Countries. Geneva: World Health Organization, 2006. Web. <<http://www.wpro.who.int/publications/docs/EHRmanual.pdf>>.
- 58 Lewis, Trevor, et al. "E-health in low- and middle-income countries: findings from the Center for Health Market Innovations." *Bulletin of the World Health Organization* 90 (2012): 332–340. Web. 23 Feb. 2016. <<http://www.who.int/bulletin/volumes/90/5/11-099820/en/>>.
- 59 Fraser, H. S. F. and J. Blaya. "Implementing medical information systems in developing countries, what works and what doesn't." *AMIA Annu Symp Proc*. (2010): 232–236. Web. <<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3041413/>>.
- 60 Ibid.
- 61 "Essential medicines and basic health technologies for noncommunicable diseases: towards a set of actions to improve equitable access in Member States." WHO Discussion Paper. Geneva: World Health Organization, 2015. Web. <http://www.who.int/nmh/ncd-tools/targets/Final_medicines_and_technologies_02_07_2015.pdf>.
- 62 Evans, David B, Riku Elovainio, and Gary Humphreys. "Health systems financing: the path to universal coverage." *The World Health Report*. Geneva: World Health Organization, 2010. Web. <http://apps.who.int/iris/bitstream/10665/44371/1/9789241564021_eng.pdf>.
- 63 Ibid.
- 64 Ibid.
- 65 Ibid.
- 66 Jarvis, Jordan. "JORDAN JARVIS, THE LANCET YOUTH COMMISSION ON ESSENTIAL MEDICINES POLICIES." 29 Feb. 2016. Web. 22 Mar. 2016. <<http://www.unsgaccessmeds.org/inbox/2016/2/29/0c87t0dtsq8u5k6rcrci4ttc8d2sw7q>>.
- 67 Evans, David B, Riku Elovainio, and Gary Humphreys. "Health systems financing: the path to universal coverage." *The World Health Report*. Geneva: World Health Organization, 2010. Web. <http://apps.who.int/iris/bitstream/10665/44371/1/9789241564021_eng.pdf>.



- ⁶⁸ Wagner, A. K., J. P. Thompson, and D. Ross-Degnan. "Social Business Interventions to Improve Access to Medicines." Maryam Bigdeli, David Peters, and Anita Wagner. AHPSPR Flagship Report 2014 - Medicines in Health Systems: Advancing access, affordability and appropriate use. Geneva: World Health Organization, 2014. Web. <http://www.who.int/alliance-hpsr/resources/FR_Ch5_Annex4.pdf>.
- ⁶⁹ Ibid.
- ⁷⁰ Ibid.
- ⁷¹ Ibid.
- ⁷² "GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013-2020." Geneva: World Health Organization, 2013. Web. <http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf>.
- ⁷³ Hod, M et al. "The International Federation of Gynecology and Obstetrics (FIGO) Initiative on Gestational Diabetes Mellitus: A Pragmatic Guide for Diagnosis, Management, and Care." International Journal of Gynecology and Obstetrics. 131(3) 2015. Web. <http://www.ijgo.org/pb/assets/raw/Health%20Advance/journals/ijg/FIGO_Initiative_on_GDM.pdf>
- ⁷⁴ "GLOBAL ACTION PLAN FOR THE PREVENTION AND CONTROL OF NONCOMMUNICABLE DISEASES 2013-2020." Geneva: World Health Organization, 2013. Web. <http://apps.who.int/iris/bitstream/10665/94384/1/9789241506236_eng.pdf>.
- ⁷⁵ Fall, CH. "Fetal malnutrition and long-term outcomes." Nestle Nutr Inst Workshop Ser. 74 (2013): 11-25. Web. 22 Mar. 2016. <<http://www.ncbi.nlm.nih.gov/eproxy.cul.columbia.edu/pubmed/23887100>>.
- ⁷⁶ Jamison, Dean T., et al. "Global health 2035: a world converging within a generation." The Lancet 382.9908 (2013): 1898-1955. Web. <[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)62105-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62105-4/fulltext)>.
- ⁷⁷ "Global status report on noncommunicable diseases 2014." Geneva: World Health Organization, 2014. Web. <http://apps.who.int/iris/bitstream/10665/148114/1/9789241564854_eng.pdf?ua=1> .
- ⁷⁸ Jamison, Dean T., et al. "Global health 2035: a world converging within a generation." The Lancet 382.9908 (2013): 1898-1955. Web. <[http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)62105-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)62105-4/fulltext)>.
- ⁷⁹ "Scaling up action against noncommunicable diseases: how much will it cost?" Geneva: World Health Organization, 2011. Web. <http://apps.who.int/iris/bitstream/10665/44706/1/9789241502313_eng.pdf>.
- ⁸⁰ Chaloupka, F., A. Yurekli, and G. Fong. "Tobacco taxes as a tobacco control strategy." Tob Control 21 (2012): 172-180. Web. <<http://tobaccocontrol.bmj.com/content/21/2/172.full>>.
- ⁸¹ "Scaling up action against noncommunicable diseases: how much will it cost?" Geneva: World Health Organization, 2011. Web. <http://apps.who.int/iris/bitstream/10665/44706/1/9789241502313_eng.pdf>.
- ⁸² Chaloupka, F., A. Yurekli, and G. Fong. "Tobacco taxes as a tobacco control strategy." Tob Control 21 (2012): 172-180. Web. <<http://tobaccocontrol.bmj.com/content/21/2/172.full>>.
- ⁸³ "Scaling up action against noncommunicable diseases: how much will it cost?" Geneva: World Health Organization, 2011. Web. <http://apps.who.int/iris/bitstream/10665/44706/1/9789241502313_eng.pdf>.
- ⁸⁴ Escobar, Maria A Cabrera, et al. "Evidence that a tax on sugar sweetened beverages reduces the obesity rate: a meta-analysis." BMC Public Health 13 (2013). Web. <<http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1072>>.
- ⁸⁵ "Assessing national capacity for the prevention and control of noncommunicable diseases." Report of the 2013 Global Survey. Geneva: World Health Organization, 2014. Web. <http://www.who.int/chp/ncd_capacity/NCD_CCS_2013_report.pdf?ua=1>.
- ⁸⁶ "Women's Activities in the Food Chain; Influence on Family Nutrition. United Nations. Web. <<http://www.unsystem.org/scn/archives/npp04/ch10.htm>>
- ⁸⁷ "Sport and Gender: Empowering Girls and Women." United Nations. Web. <http://www.un.org/wcm/webdav/site/sport/shared/sport/SDP%20IWG/Chapter4_SportandGender.pdf>
- ⁸⁸ "About Accredited Social Health Activist (ASHA)." 2 Sep. 2014. Web. <<http://nrhm.gov.in/communitisation/asha/about-asha.html>>.
- ⁸⁹ Ibid.
- ⁹⁰ "AUSTRALIAN PROGRAM WINS WORLD HEALTH ORGANISATION AWARD." 3 Jul. 2013. Web. 23 Feb. 2016. <<http://netball.com.au/australian-program-wins-world-health-organisation-award/>>.
- ⁹¹ Ibid.
- ⁹² "Improving health outcomes for women in Tonga through Netball." Australian Sports Commission. July 2015. Web. <http://www.ausport.gov.au/_data/assets/pdf_file/0004/637627/Improving_health_outcomes_for_women_in_Tonga_through_Netball.pdf>
- ⁹³ "Path to Good Health: Tonga National Strategy to Prevent and Control Non Communicable Diseases (2010 - 2015)." Geneva: World Health Organization, n.d. Web. 23 Feb. 2016. <<https://www.mindbank.info/item/1168>>.
- ⁹⁴ "KAU MAI TONGA." n.d. Web. 23 Feb. 2016. <<http://netball.com.au/kau-mai-tonga/>>.
- ⁹⁵ Ibid.
- ⁹⁶ "Improving health outcomes for women in Tonga through Netball." Australian Sports Commission. July 2015. Web. <http://www.ausport.gov.au/_data/assets/pdf_file/0004/637627/Improving_health_outcomes_for_women_in_Tonga_through_Netball.pdf>
- ⁹⁷ "From Burden to 'Best Buys': Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries." Geneva: World Health Organization and World Economic Forum, 2011. Web. <<http://apps.who.int/medicinedocs/documents/s18804en/s18804en.pdf>>.
- ⁹⁸ Goldie, Sue J. and Steven Sweet. "Global Cervical Cancer Prevention: Health and Economic Benefits of HPV Vaccination and Screening." Summary of Prior Work. Boston: Harvard School of Public Health, 2013. Web. <<http://globalhealth2035.org/sites/default/files/working-papers/summary-1-cervical-cancer-prevention-cih.pdf>>.
- ⁹⁹ Ibid.
- ¹⁰⁰ "From Burden to 'Best Buys': Reducing the Economic Impact of Non-Communicable Diseases in Low- and Middle-Income Countries." Geneva: World Health Organization and World Economic Forum, 2011. Web. <<http://apps.who.int/medicinedocs/documents/s18804en/s18804en.pdf>>.
- ¹⁰¹ Ibid.

