POLICY BRIEF

Ensure Access to Comprehensive Health Services

Facts, Solutions, Case Studies, and Policy Recommendations

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 break down these barriers. This brief discusses some of the approaches that can help communities improve the access that girls and women have to a comprehensive range of services their enjoyment of rights physical and mental health. Included among these approaches 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, girls and women 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, in a number of geographical contexts, it remains unaffordable and inaccessible for many. Adequate healthcare is often out of reach when it comes to treating non-communicable diseases (NCDs) that develop slowly over time, such as cardiovascular disease, diabetes, and cancer.[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] for adolescent girls, it is the leading cause of death.[6] In developing countries, 15.9% of pregnant women and 19.8% of women who have just given birth experience a mental disorder.[7] Moreover, 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.[8] The reverse effect is true as well: despite limited research on the topic, mental health issues such as depressive disorders have been shown to hold an important role in the development and outcomes of chronic disease.[9]

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.[10] In some cultures, women have limited access to household resources, have restricted mobility, or may be prevented from making decisions about their own care.[11] 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.[12]

➔ *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.[13] 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. For example, in 2016, a WHO report described a detailed framework, strategies, and policy options for integrated, people-centered health services.[14] The framework sets forth a world in which "all people have equal access to quality health services that are co-produced in a way that meets their life course needs, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient, and acceptable."[15]

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 girls and women

Ensuring access to comprehensive healthcare for girls and women is linked to the achievement of multiple SDG goals 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

- Increase investments in integrated healthcare services, particularly at the primary care level
- Optimize health workforce resources to enhance both the continuum and 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 safe and accessible
- Ensure prevention, screening, and treatment options for non-communicable diseases

Implement People-Centered Care, with a Focus on Women[1]

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, Particularly at the Primary Care Level

There are many strategies to integrating health service delivery, and a World Health Organization framework containing five key strategies has been developed.[26] These include 1) engaging and empowering people and communities; 2) strengthening governance and accountability; 3) reorienting the model of care by training providers to offer various services and placing multiple services at the same facility; 4) coordinating services within and across sectors by providing referrals as needed among service providers; and 5) creating an enabling environment.[27] 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.[28,29]

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.[30] And where treatment of stigmatized diseases, such as HIV, is integrated with other services, concerns about disclosure are reduced.[31,32] Integrated care provision has also been shown to normalize HIV testing.[33]

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.[34] By the end of 2017, DREAMS will achieve a 40% reduction in HIV incidence among girls and women ages 15–24 in the hardest-hit areas.[35]

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-

- **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

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

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 LMICs to deliver HIV-related services and essential interventions for maternal and newborn health.[36,37]

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. In a systematic review of 53 studies, the quality of care for maternal and child communicable and non-communicable diseases provided by mid-level health professionals was similar to the quality of care provided by higher-level health professionals.[38]

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 NCDs and other chronic conditions.[39] A review of studies utilizing community health workers for prevention and detection of NCDs in LMICs found that community health worker involvement resulted in improvements in tobacco sensation, lowering blood pressure, and diabetes management.[40] However, due to the small number of studies and low-quality evidence currently available, research must be expanded.[41,42,43]

When disasters and emergencies take place, the health consequences can be devastating—resulting in loss of life and disability—and the health workforce is often a victim as well.[44,45] Health service delivery becomes more complicated in these emergency settings, but maintaining the health workforce is especially important for building resilience, reducing health vulnerability, and recovering from the emergency itself.[46] Greater focus on the health workforce in the case of emergencies is needed, especially in terms of staffing requirements, surge capacity, training, and preparedness.[47,48]

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.[49] 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.[50] The full package is based upon hospital reform initiatives, model centres of excellence, education reforms and social marketing.[51] 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.[52] Results of this program boasted healthier newborns, increased satisfaction from mothers, and overall facility cost savings.[53]

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.[54,55]

Universal Health Coverage seeks to provide services for all while protecting patients from financial hardship.[56] More than 100 LMICs, home to three-quarters of the world's population, have taken steps to pursue UHC.[57] All countries can make progress towards UHC, even those with low levels of public spending on health (less than US $40 per capita).[58] However, as the amount of public spending increases, there is generally more systematic improvement in health system performance.[59] 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.[60,61,62,63]
- **Pooling resources across the population:** This allows the redistribution of resources from the wealthy to the poor and from the healthy to the sick.[64,65,66] 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.[67]
- **Strategically designing benefits packages:** Although the benefits packages may vary, they should respond to the needs of women and low-income populations.
- **Improving medicines-related efficiency:** Buy at the lowest cost through transparent, competitive bidding; test and ensure quality throughout the distribution chain; modify regulations to encourage the use of generics; and encourage rational use of all medicines.[68]

- **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 settlements 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

Relevant International Agreements:

- 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)
- WHO Mental health action plan (2013–2020)
- Sustainable Development Goals (SDGs) (2015–2030)
- Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents (2017)

- **Task shifting:** Allow health workers at lower levels to take on more responsibility as appropriate.[69]
- **Assessing status quo and plans for reform:** Determine primary causes of current system inefficiencies and which are feasible to change in the short, medium, and long term.[70] Develop a set of efficiency indicators specific to the country, and invest in methods to collect indicator data and to evaluate progress.[71]
- **Using intersectoral planning for health equity:** Incorporate the social determinants of health into planning by engaging other sectors of the government from the beginning, consulting the community and civil society, and examining existing inequities.[72]

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.[73,74,75] 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.[76,77] However, appropriate measures need to be taken to offset the loss of revenue and respond to the increased demand for services.

Case Study: Indonesia Makes Strides Toward UHC

Over the past 20 years, Indonesia has undergone a number of improvements in key health indicators and has made progress towards UHC.[78] By the end of 2016, nearly 172 million individuals—over 60% of the population—were covered by the Jaminan Kesehatan Nasional (JKN) program, one of the largest single-payer social health insurance schemes.[79] National targets aim to reach the remaining population and to have universal coverage by 2019.[80] Meanwhile, Indonesians have become healthier in terms of a number of key health indicators.[81] For example, they have seen declines in the under-five mortality rate, from 222 per 1,000 live births in 1960 to 27 per 1,000 in 2015.[82] Life expectancy has increased to 69 years in 2014, up from 63 in 1990.[83] However, as a larger share of the burden of disease shifts to NCDs, Indonesia will need to adapt to higher utilization of its health system and shift towards more preventative rather than curative care.[84]

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

Individual medical records are the backbone of comprehensive care for girls and 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.[85] 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.[86]

Another innovative strategy, originally driven by HIV and TB programs, is the use of electronic medical record systems.[87] 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.[88] 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.[89,90] Some studies have shown that they can also support the chronic clinical management of HIV and TB patients.[91]

Ensure Medical Products and Technologies Are Safe and Accessible

Equitable access to comprehensive health services requires the availability of essential medicines, vaccines, and technologies. In reality, some medicines are chronically unavailable in LMICs as a result of countries failing to include medicines on the essential drug list,[92] inefficiencies in procurement and distribution systems, and unnecessarily high prices.[93]

Countries should implement the framework recommended by the WHO to ensure equitable access to high quality, safe, and cost-effective medicines.[94] It includes the following components:

- **Rational selection of medicines:** Countries must develop active purchasing based on the costs and benefits of alternatives.[95]
- **Affordable pricing:** Governments should ensure transparency in purchasing and tenders by monitoring and publicizing medicine prices.[96] Policies that support the purchase of generic drugs (the norm for HIV/AIDS) should be extended to NCDs.[97]
- **Remove taxes and duties:** Countries should use their negotiating power to control mark-up, addressing excessive taxes and duties on medicines.[98]
- **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.[99]
- **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.[100]

In the case of emergency situations, medicines and medical devices must be available and standardized to allow for their efficient, effective, and safe usage when the need arises.[101] Health systems can train on how to use standardized packages of essential medicines, supplies, equipment, and other information, including mental health care and the special health needs of children during conflicts and emergencies.[102]

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.[103] 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.[104]

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.[105] 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.[106] 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 unhealthy diet—is a cornerstone of the Global NCD action plan.[107] 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.[108]

Increased access to point-of-care (POC) diagnostic testing, bringing services closer to women, children and families has been shown to improve patient care, especially in settings with limited laboratory infrastructure and where the bulk of the population lives in rural settings.[109] POC CD4 diagnostic testing, to monitor immune function in patients with HIV improves linkage to HIV care and timeliness of antiretroviral initiation.[110]

When disasters and emergencies take place, health service delivery becomes more complicated: following a coup in Mali in 2012, the health system was severely impacted.[111] NGO Santé Diabète developed a humanitarian response for patients with diabetes that included evacuating children, providing medicines and tools for management of diabetes, and supporting people who became internally displaced.[112] People with NCDs should be viewed as vulnerable in emergency settings and as having specific needs.[113] Emergency responses should be tailored to the patients' particular context, such as whether they are internally displaced or if they remain in conflict areas.[114]

Governments play an important role in promoting healthy behaviors through policies and tools—within and outside of the traditional health sector.[115,116] 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.[117,118] For example, many studies show that taxing tobacco reduces its use and can prevent deaths, while also raising revenue.[119,120] Taxation on alcohol and sugar-sweetened beverages can provide similar benefits.[121,122,123] 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.[124]

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.[125] Girls and women 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.[126]

Case Study: ASHA—Women as Community Health Workers in India.
India's National Rural Health Mission was launched in 2005, aiming is to provide every village in the country with a trained female community health activist Accredited Social Health Activist (ASHA).[127] ASHAs serve as a link between their own community and the public health system. As community health activists, ASHAs provide education on prevention of a range of health issues, including reproductive and sexual health, and healthy lifestyles and nutrition to contribute to the prevention of diabetes and other NCDs.[128] ASHAs also counsel women about immunization and receive performance-based incentives for promoting universal immunization, connecting community members to immunization services at health centers.[129]

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.[130] In partnership with the Tonga Netball Association (and support from the Australian Sports Outreach Program),[131] the campaign—Kau Mai Tonga: Netipol (Come on Tonga, let's play netball!)—used netball as a means of encouraging activity.[132] Guided by the Tonga National Strategy to Prevent and Control Non-Communicable Diseases (2010–2015),[133] the campaign employs community mobilization, large-scale advertising, communication, and interpersonal education.[134] Since the launch in 2012,[135] 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.[136]

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. The returns on investment in health are 9 to 1, and an estimated quarter of the growth between 2000 and 2011 in LMICs resulted from improvements to health.[137] Scaling up the full package of clinical and outreach interventions for NCDs to 80% coverage across 42 LMICs, 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.[138] In order to make significant progress on SDG 3 in LMICs by 2030, an additional US $371 billion in health spending would be needed each year, with 75% of that cost going toward health systems strengthening.[139] As a result, 97 million lives would be saved and life expectancy would increase by 3–8 years.[140]

Integrating prevention and control of NCDs within other programmatic areas, such as HIV, maternal, newborn, and child health, and sexual and reproductive health, may enhance synergies and linkages, and improve efficiencies in the delivery of services to women and families in low and middle income countries.[141] Taking action to expand and improve the health workforce also brings about benefits in terms of job creation, economic growth, social welfare, and gender empowerment, in addition to health system strengthening.[142]

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 US $10 to $25 per person—would avert more than 3 million deaths from cervical cancer across 72 LMICs.[143] Additionally, screening vaccinated women for cervical cancer just three times in their lifetime would reduce mortality by another 20-25%.[144]

While significant progress has been made on curbing the HIV epidemic, marginalized groups, including girls and women, are still vulnerable in many communities.[145] A global comprehensive care effort for HIV—including prevention packages, human rights protections, and accelerated testing and treatment—would avert 28 million HIV infections between 2015 and 2030, resulting in 21 million fewer deaths and avoiding US $24 billion in HIV treatment costs.[146] In total, countries would reap a 15-fold return on their HIV care investments.[147]

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 LMICs 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.[148]

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 LMICs by US$25 billion each year.[149] 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, women-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 and in emergency and conflict settings.
  (Most relevant for: governments, civil society, the United Nations, and the private sector)
- Build and disseminate evidence of the impact of women-centered care.
  (Most relevant for: governments, civil society, academia, media, affected populations, the United Nations, and the private sector)

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Prepared by: Aurelie Brunie, FHI 360

Reviewed by: Genine Babakian, Consultant; Shannon Barkley, WHO; Mary Crippen, Consultant; Juliana Bennington, Women Deliver; Maria DeVoe, Women Deliver; Tatiana DiLanzo, Women Deliver; Rebecca Dirks, FHI360; Louise Dunn, Women Deliver; Katja Iversen, Women Deliver; Lisa Kruitbosch, CHOICE for Youth and Sexuality; Crystal Lander, Management Sciences for Health; Jessica Malter, Women Deliver; Mona Moore, FHI360; Susan Papp, Women Deliver; Savannah Russo, Women Deliver; Liuba Grechen Shirley, Consultant; Petra ten Hoope-Bender, Women Deliver; Tamara Windau-Melmer, Women Deliver; Nuria Toro, WHO; Youth Coalition for Sexual and Reproductive Rights

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ENDNOTES

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[148] "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>.

[149] Ibid.