

Access to sexual and reproductive health services in the Region of the Americas



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REGION OF THE AMERICAS

Access to sexual and reproductive health services in the Region of the Americas

Washington D.C., 2024

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PAHO/HSS/CLP/24-0002

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This summary was prepared at CLAP under the coordination of Dr. Suzanne Serruya and Dr. Rodolfo Gómez Ponce de León with the collaboration of Sonja Caffè, Silvina Ramos, Julia Frenkel, Melina Pais and Thais A. Forster.

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This brief presents the guidelines and agreements in the information document “Status of access to sexual and reproductive health services”, prepared by the Pan American Health Organization (PAHO) at the request of its Member States at the 30th Pan American Sanitary Conference.

Its objective is to describe the status of access to sexual and reproductive health services in the Americas region, identify health responses and barriers to access, and suggest recommendations for countries. It was developed based on a review and systematization of data, plans and initiatives, scientific papers, United Nations reports, and legal and regulatory frameworks on sexual and reproductive health.

The information document was presented and unanimously approved by the countries of the Region of the Americas at the 60th Meeting of the Directing Council, 75th session of the WHO Regional Committee for the Americas, held in Washington, D.C., USA, September 25-29, 2023. ●

- Pan American Health Organization. Status of the access to sexual and reproductive health services. [Resolution CD60/INF/4]. 60.º Directing Council, 172.º Session of the Regional Committee of WHO for the Americas; 25–29 September 2023. Washington, DC: PAHO; 2023. Available from: <<https://www.paho.org/en/documents/cd60inf4-status-access-sexual-and-reproductive-health-services>>.



60th Meeting of the Directing Council held in Washington, DC - September 25-29, 2023.



Sexual and reproductive health (SRH) is the general state of physical, mental, and social well-being, and not merely the absence of disease, in all matters relating to the reproductive system, its functions and processes. It involves the right to

enjoy a satisfying sexual life free of coercion, discrimination and violence, and the freedom to decide about procreation.¹

Sexual and reproductive health and the commitments made

PAHO Member States are committed to targets 3.7 and 5.6 of the Sustainable Health Agenda for the Americas 2018-2030, both linked to sexual and reproductive health, as well as to the Strategy for Universal Access to Health and Universal Health Coverage, which recognizes that all individuals and communities should have access to adequate, timely, and quality comprehensive health services and supplies, with no discriminations. This report is in line with the Plan of Action for Women's, Children's and Adolescents' Health 2018-2030, as the indicators and targets of the plan are its guiding references. Countries and territories have also committed to address the causes of disparities in terms of access to and utilization of health services by lesbian, gay, bisexual and trans (LGBT)[•] persons with full respect for dignity and human rights, taking into account the diversity of gender expression and gender identity, without discrimination.

PAHO's Strategic Plan 2020-2025 includes indicators to monitor progress in access to sexual and reproductive health services linked to Sustainable Development Goals 3 and 5, as well as with target 1.4 of the Sustainable Health Agenda for the Americas 2018-2030.

¹ World Health Organization. Developing sexual health programmes: a framework for action. Geneva: WHO; 2010. Available at: <<https://apps.who.int/iris/handle/10665/70501>>.

PAHO Member States have adopted national plans of action and strategies related to sexual and reproductive health, with special attention to vulnerable population groups.

- PAHO uses the acronym “LGBT” in accordance with resolution CD52. R6 (2013), Addressing the causes of disparities in access to and utilization of health services by lesbian, gay, bisexual, and transgender 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 the acronym “LGBTQI+”, which refers to lesbian, gay, bisexual, transgender, queer, intersex and (+) people, where the (+) symbol is intended to include a broader range of sexual orientations and gender identities (asexual and pansexual people, among others).

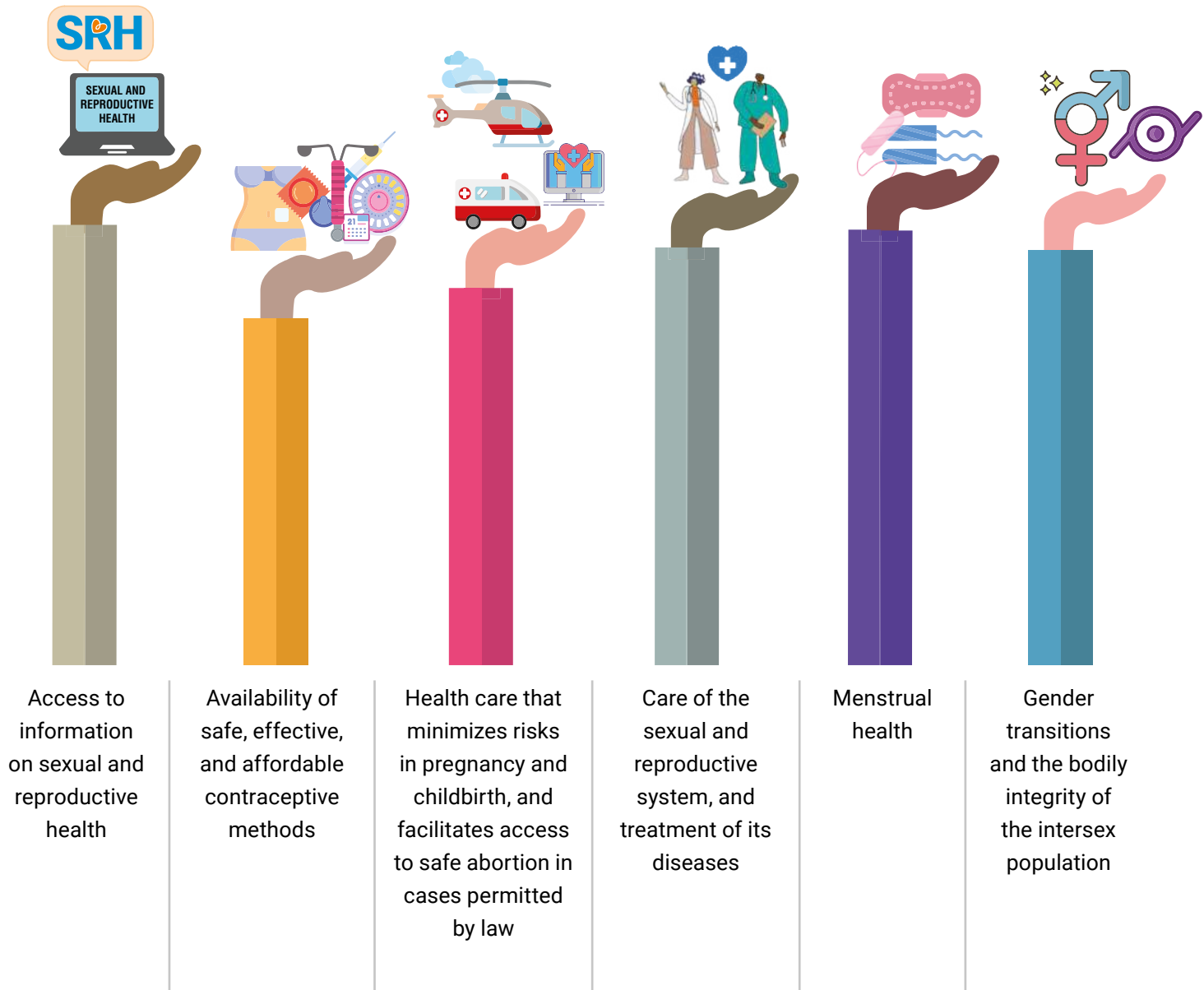


It is key to guarantee access to sexual and reproductive health services as a fundamental right of all individuals.

Services are essential to promote gender equality, well-being, and autonomy of people, as well as to prevent diseases and promote a healthy sexual life.”

Representative of Uruguay at the 60th Directing Council, 75th Session of the WHO Regional Committee for the Americas, held in Washington, D.C., USA, September 25-29, 2023.

Sexual and reproductive health services must guarantee:



Investing in sexual and reproductive health implies important benefits for States, societies and individuals, while not doing so results in significant losses.

SRH services enable people to decide if and when to have children, to enjoy safe pregnancies and deliveries, to have healthy babies, and to have a safe and satisfying sex life.

An investment of USD 12.73 per capita per year – merely adding USD 1.33 *per capita* to the current spending – would cover modern contraceptive services, maternal and newborn care, safe abortion services, and STI treatment for all women in LAC requiring them.

Every dollar spent on contraceptive services above the current level would save USD 3.61 in the cost of maternal care, newborn care, and abortion services because contraception reduces unintended pregnancies.

Failure to invest in the prevention of unintended pregnancy in adolescence has an impact on the course of national economies, compromising their growth and development potentials.

Failure to invest in the prevention of unintended pregnancy in adolescence leads to income losses for women due to truncated educational trajectories and more precarious labour insertion, as well as loss of tax revenue and higher health expenses for the States, with an average cost of 0.35% of GDP for six Latin American countries, the equivalent of USD 1,242 million per country and per year.[●]

- Sully EA, Biddlecom A, Darroch JE et al. Adding it up. Investing in sexual and reproductive health 2019. New York: Guttmacher Institute; 2020. <https://www.guttmacher.org/sites/default/files/report_pdf/adding-it-up-investing-in-sexual-reproductive-health-2019.pdf>.

1.

Over the last 20 years, most countries have improved coverage of SRH services: 81.3% in the region, above the world average of 74%. (2021)

Marked heterogeneities between countries and inequalities in access and health status among subpopulations: the composite SRH coverage index ranges from 37.9% to 84.5% in the lowest income quintile and from 65.3% to 89.6% in the highest quintile. (2021)

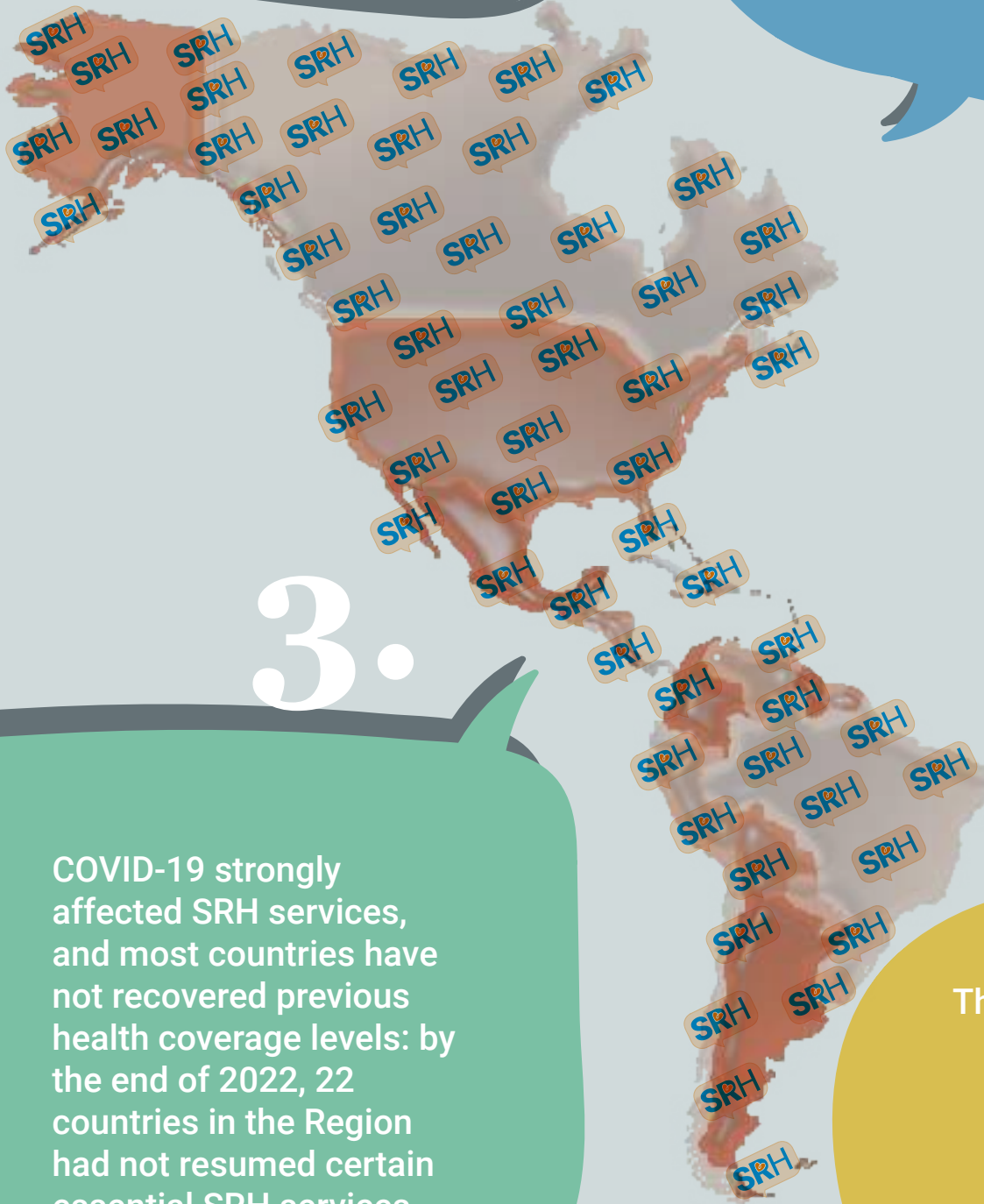
2.

3.

COVID-19 strongly affected SRH services, and most countries have not recovered previous health coverage levels: by the end of 2022, 22 countries in the Region had not resumed certain essential SRH services

4.

There are effective interventions already implemented by countries in the region for key SRH problems



Contraception



The problem

Universal access to methods of contraception (MC) has been enshrined in global and regional commitments since the 1994 International Conference on Population and Development, recognizing the right of individuals to plan their reproductive future, and in the understanding that access to contraception prevents unintended pregnancies and unsafe abortions.

However, there are multiple barriers to access to contraception that prevent women and persons of childbearing capacity from exercising their right to decide about their reproductive future:

- 
- a.** restrictive legal and regulatory frameworks (especially those concerning the lack of autonomy of girls and adolescents);
 - b.** lack of financial coverage of the methods or the services associated with their use;
 - c.** complexity of the administrative provision procedures and medical instructions given in a language that is difficult to understand;
 - d.** discontinuity in the availability of supplies;
 - e.** understaffed health care services, and low sustainability of public allocations for the procurement and provision of modern methods;
 - f.** lack of confidentiality and privacy;
 - g.** mobilization barriers;
 - h.** social values that hinder access to sexuality education;
 - i.** unfriendly attitudes of health care teams;
 - j.** weakness of legal and regulatory frameworks to ensure the evaluation of programs;
 - k.** lack of empowerment of women in vulnerable situations.

Where are we?

Prior to the COVID-19 pandemic, progress had been made in the uptake of contraception among women of reproductive age and the total fecundity rate was dropping. Unmet needs for contraception had also been declining steadily. Yet, there were significant inequities in terms of the extent to which the need for modern method contraception was met by the various countries and within each country.

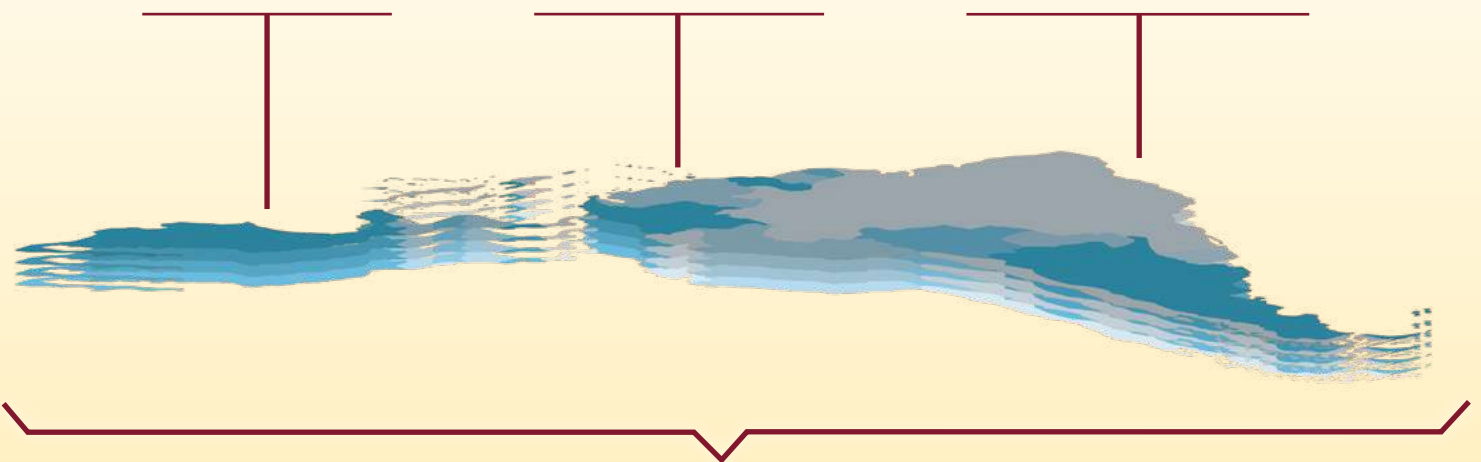
The COVID-19 pandemic affected access to contraception because of disruptions in public provision and because people had trouble affording contraceptive methods. An estimated 12.9 to 20.1 million women in Latin America and the Caribbean were forced to discontinue their modern contraceptive methods during the COVID-19 pandemic.

Access to modern Long-acting reversible contraception methods (LARC) before the COVID-19 pandemic

Only 10 of 23 countries in Latin America and the Caribbean are meeting $\geq 80\%$ of their demand for contraception with modern long-acting contraceptive methods.

In 17 out of 23 countries in Latin America and the Caribbean, the use of long-acting reversible contraceptive methods like IUD and subdermal implants is below 10%.

Young women aged 15-17 years, indigenous and Afro-descendant women, women in lower wealth quintiles, women in rural areas, and women with no education have even lower rates of long-acting reversible contraceptive use.



National SRH policies that are being implemented include the provision of modern contraceptive methods through social or private insurance, but the coverage of public programs is very low: the proportion of users who receive them free of charge ranges from 32.2% to 68.6% depending on the country; and about half of those who use modern contraceptive methods purchase them in pharmacies and pay for them out of pocket.

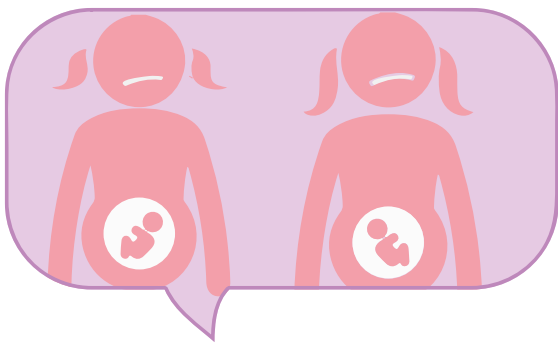


What should we do?

There are proven evidence-based interventions to increase access to contraception:

- integration of trained, equipped and supported community health workers (CHWs) at the first level of the health system
- postpartum and post-abortion family planning services in health facilities
- social marketing for distribution of a wide range of contraceptive methods and promotion of healthy family planning behaviours
- mobile outreach services for the provision of contraceptive methods, including long-acting contraceptives and permanent methods.²

² Mickler AK, Carrasco MA, Raney L et al. Applications of the High Impact Practices in Family Planning during COVID-19. *Sex Reprod Health Matters*. 2021; 29(1): 1881210. doi: 10.1080/26410397.2021.1881210



Adolescent pregnancy

The problem

Adolescent pregnancy is a consequence of the violation of several rights: to education, to sexual education, to access to information on sexual and reproductive health, to access to effective contraceptive methods, to a life free of violence of all kinds, and to make free and informed decisions about sexual life and reproduction.

Adolescent pregnancy and early motherhood have a negative impact on several levels:

Women's life trajectory: higher school dropout rates, difficulties in entering the labour market and accessing quality jobs, and lower lifetime earnings

Lower consolidated productivity of the countries.

Health problems: increased risk of maternal morbidity and mortality, perinatal complications and mortality, prematurity, low birth weight, poorer infant nutritional status and impact on the mental health of adolescent mothers..

Persistence of intergenerational cycles of poverty and poor health.

The determinants of adolescent pregnancy are manifold and operate in a systemic manner:

- a. Legal or social acceptance of child marriage;
- b. Early sexual initiation;
- c. Child sexual abuse, gender-based violence and other forms of violence;
- d. Homelessness;
- e. Absence of comprehensive sexuality education (CSE) policies;
- f. Restrictive legal or administrative rules for access to contraceptive methods and abortion;
- g. Geographic, financial or attitudinal barriers hindering access to sexual and reproductive health services; and
- h. Unequal norms, gender roles and relations

The large number of adolescent pregnancies is not due to reproductive preferences but to risk factors linked to situations of vulnerability and violation of rights, as well as to barriers in the access to SRH services and, specifically, to modern contraception.



Reducing teenage pregnancy is primarily a development strategy because it can reduce intergenerational poverty in the poorest families in the region, which are families whose head of household is a woman who generally had a teenage pregnancy.”

Suzanne Serruya, Director of the Latin American Center for Perinatology, Women's and Reproductive Health, PAHO at the 60th Directing Council, 75th Session of the WHO Regional Committee for the Americas, held in Washington, D.C., USA, September 25-29, 2023

Where are we?

In the last decade, the prevention of adolescent pregnancy has become increasingly important in national health and development agendas.

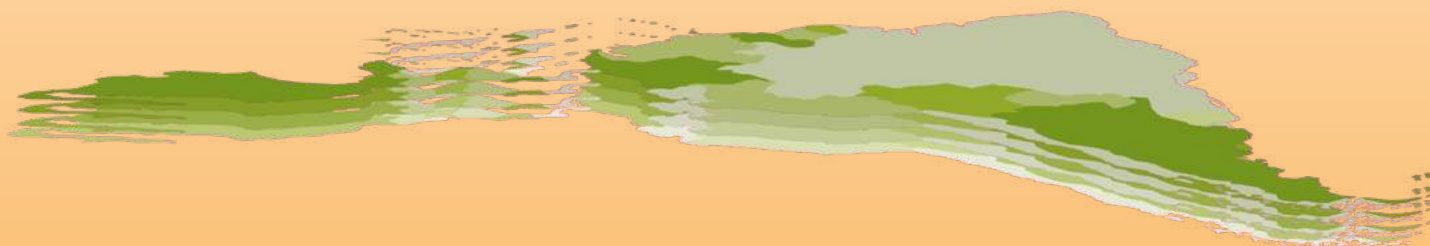
Interventions focused on the school, the family and the adolescent population have been implemented, but Comprehensive Sexuality Education policies and access to long-acting reversible contraceptive methods have not been systematically implemented or have lacked proper continuity, and their institutionalization and scale up still pose challenges.

Adolescent fecundity rate (AFR) for 15-19 year olds

The 15-19 years AFR in Latin America and the Caribbean fell by 7.47% in a decade, going from 66.5% in 2010-2015 to 60.7% in 2015-2020, with significant variations between subregions and countries.

There are also important inequalities within countries: the AFRs of girls and adolescents from poorer, less educated, rural, indigenous and Afro-descendant segments are three to five times higher than the national averages.

They also suffer more adverse health consequences in relation to other risk factors: sexual abuse, bullying and other forms of violence, homelessness or problematic drug use.



What should we do?

There is evidence and broad consensus on the actions needed:

- collect, analyse, and use precise and up-to-date health data on contraceptive use and its determinants, and on program performance and adolescent sexuality and fertility to inform laws and policies
- formulate or revise laws and policies to reduce barriers to access to comprehensive sexual and reproductive health services and Comprehensive Sexuality Education with evaluation mechanisms
- implement cross-sectoral and community strategies, engaging adolescents
- develop national adolescent sexual and reproductive health strategies that include evidence-based and context-specific interventions, with sufficient budgets and indicators disaggregated by age and socioeconomic status to track progress
- monitor strategies with input from stakeholders (government officials, NGOs, UN agencies, youth organizations and networks, donors, parents, teachers, and community members)
- conduct periodic reviews of programs and compliance with legal and regulatory frameworks

Comprehensive Sexuality Education empowers adolescents to make free and informed decisions about their bodies, their lives, and their future; it reduces sexually transmitted infections (STIs), human immunodeficiency virus (HIV) infection and unintended pregnancies and improves sexual and reproductive health indicators.



Sexual violence is part of the social determinants of unintended pregnancy. Establishing an adequate criterion to comprehensively address unintended pregnancies in girls is of paramount importance. It is a multi-causal problem that requires, in addition to an intersectoral approach, a view that considers the multiple oppressions and exclusions that converge in the life trajectories of girls and female adolescents in the region.”

Representative of Argentina at the 60th Directing Council, 75th Session of the WHO Regional Committee for the Americas, held in Washington, D.C., USA, September 25-29, 2023.





Unsafe abortion

The problem

Unsafe abortion is a public health problem because of its high prevalence and the negative consequences it has on people's health and lives. It is also an equity issue.

It disproportionately affects vulnerable populations: where it is not legally prohibited, girls who are victims of sexual violence, adolescents, women living in poverty, people with disabilities, women living in areas far from large cities, and migrants find it much harder to access quality and timely abortion services.

Inequality is due to multiple access barriers: a) personal and interpersonal: lack of information about the right to abortion and how to access services, late recognition of pregnancy, lack of support from the environment or sexual partner; b) logistical: distance, mobility, difficulties in leaving home and/or work; c) social: stigma and social pressure; and d) health system: availability of services, referral mechanisms, limited clinical options, quality of treatment, abusive use of conscientious objection. There are also barriers linked to legal and health regulations, such as waiting times, procedure or transfer costs, and lack of health coverage.

General Comment 36 of the Human Rights Committee affirms that the protection of the right to life of women and other persons capable of bearing children implies the protection of their right to access safe abortion. Comprehensive safe abortion care is one of the interventions included in the World Health Organization (WHO) 2020 Guidance for maintaining essential health services.

Where are we?

Abortion in numbers

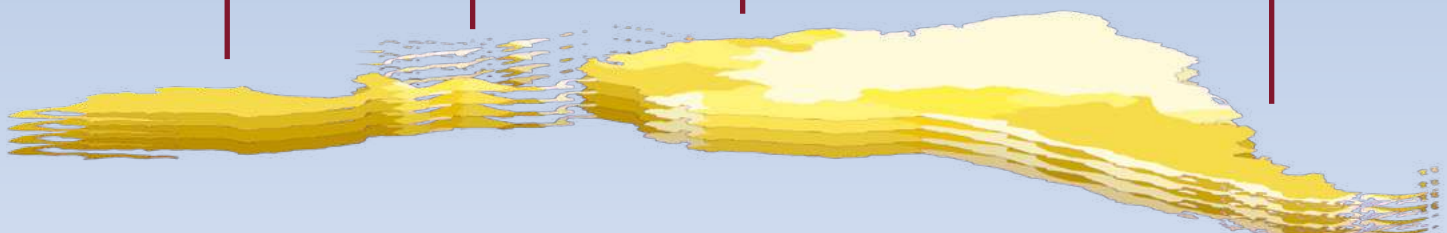
Between 2010-2014, 6.5 million abortions were performed each year in Latin America and the Caribbean, 4.89 million (75%) of these were unsafe abortions.

9.9% of maternal deaths in Latin America and the Caribbean were due to complications associated with unsafe abortion (2015).

In some countries there was a systematic increase of the indirect causes of maternal mortality attributable to deficient coverage and the poor quality of ante-natal care, as well as the lack of access to contraception and safe abortion services.

Most countries in Latin America and the Caribbean allow abortion under specific conditions: conditions that threaten the mother's life or health, fetal non-viability, rape, incest and mental health.

There are significant geographic, economic, administrative and attitudinal barriers to access to safe abortion.



Restrictive policies not only fail to reduce the number of abortions; they prevent their safe performance:

- Globally, in countries where abortion is permitted on demand, 87.4% of abortions are safe vs.
- In countries where abortion is completely prohibited or permitted only in case of life-threatening condition or when physical health is jeopardized, only 25.2% of abortions are safe.



Access to SRH is also critical to supporting the empowerment of diverse groups of women and adolescent girls. Lack of attention to SRHR contributes directly to maternal mortality, adolescent pregnancies, HIV and other STIs, poor health and the disenfranchisement of women and girls.”

Representative of Canada at the 60th Directing Council, 75th Session of the WHO Regional Committee for the Americas, held in Washington, D.C., USA, September 25-29, 2023.

What should we do?

Legally supported policies are required for:

- Improving universal and free access to modern contraception to prevent unintended pregnancies, as well as access to SRH counselling and comprehensive sexuality education for informed decision making.
- Providing quality post-abortion services to reduce illness and death associated with unsafe abortion and ensure post-abortion contraception.
- Improving policies for access to safe abortion with clinical and self-managed options (including drugs for pharmacological abortion).
- Adapting the protocols of care to WHO recommendations on the matter.
- Broadening the basis for legal abortion to reduce the number of unsafe abortions

Maternal abortion-related mortality and morbidity and unsafe abortions were reduced in countries that limited restrictions in their law and implemented access policies, and in these contexts, most abortions have occurred in the initial 12 weeks of pregnancy.





Gender-based violence

The problem

Gender-based violence has serious consequences on the physical, mental, sexual and reproductive health of girls and women. Intimate partner violence is the most common form of violence. This violence begins early and does not cease throughout women's life trajectory.

Where are we?

Gender-based violence in numbers

34% of women aged 15 to 49 years have suffered physical or sexual violence by their intimate partner or sexual violence by somebody else other than her partner at some point in their lives (2021).

1 in 4 women suffered physical or sexual violence by a partner at least once in her life.

21% of women over the age of 25 have already experienced intimate partner violence and 28% of women over the age of 65 continue to experience it.



The countries of the Region are making progress in policies to eradicate gender-based violence:

- 83% of the countries include violence prevention, care and reparation actions in health policies and plans.
- 60% of the countries have protocols and guidelines for the health systems
- 80% of the countries have a multisectoral policy for the prevention of violence against women or a national gender policy that addresses violence against women.

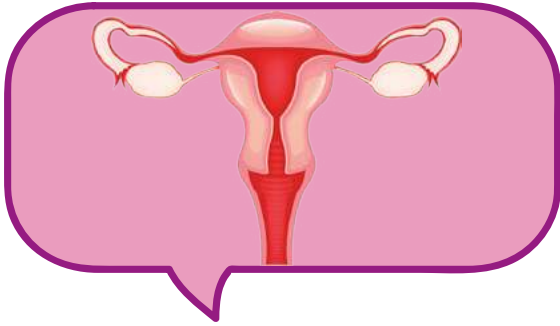
The countries of the Region show progress in the generation of information on violence against women and girls; the inclusion of the prevention, care, and reparation of violence against women in health policies and plans; the development of protocols and guidelines to orient the response of health systems; training of health professionals and strengthening the provision of comprehensive post-rape care services.

What should we do?

The health sector plays a key role in preventing violence against women and girls and mitigating its consequences: it can detect abuses early, provide quality care, and collaborate with other sectors to advance multisectoral measures.

More effort is needed to improve the quality of documents that inform the policies for the eradication of gender-based violence, their consistency with evidence, and the implementation of such policies. The more detailed the guidance, the easier it will be for health care staff to understand exactly what they are required to do.





Cervical cancer

The problem

Latin America and the Caribbean rank second in mortality due to cervical cancer globally, with the highest rates in the Caribbean, followed by South America and Central America. Although some countries have promoted legislation for the therapy of cancer, this does not respond to a comprehensive vision of prevention, early detection, access to vaccines and drugs, comprehensive information management and access to financing for catastrophic expenses.

The low level of screening and lack of early detection in vulnerable groups is due to several barriers: a) structural (socioeconomic status and level of schooling), b) cultural (beliefs and attitudes related to cervical cancer, discrimination, non-sensitive services, and misinformation and prejudices of service providers), and c) systemic barriers related to the health system (lack of access to screening and monitoring due to gaps in the technology available, poor response capacity and organization of health services).

Where are we?

The incidence and mortality of cervical cancer have declined over the last decade in the Region, but most countries and territories still have rates above the elimination threshold agreed in the WHO Global Strategy for Accelerating the Elimination of Cervical Cancer as a Public Health Problem by 2022 of 4 per 100,000 women.

Cervical cancer in numbers

Third most common cancer diagnosis and the most frequent cancer diagnosis in women in 11 of 32 countries and territories with available data

Incidence of cervical cancer is 6.1 per 100,000 women in North America;

13.8 per 100,000 women in Central America, and

15.4 per 100,000 women in South America (2020)

Cervical cancer mortality rate is 8.2 per 100,000 women in the Caribbean,

7.8 per 100,000 women in South America, and

6.8 per 100,000 women in Central America

- 39 countries and territories have HPV vaccination programs for girls and 12 of them also for boys.
- 16 countries in Latin America and the Caribbean updated their recommendations to introduce new screening tests or alternative programmatic approaches, although cytology remains the main screening test.
- Access to cancer drugs, particularly high-cost drugs, remains a challenge, and utilization of the Regional Revolving Fund for Strategic Public Health Supplies is still limited.
- More than half of the countries in Latin America and the Caribbean have poor quality records, which are essential for planning, monitoring, and evaluating national actions.

What should we do?

Advance the pillars of cervical cancer prevention, screening and treatment by implementing the actions of the Global Strategy to achieve the 90-70-90 goals and accelerate the elimination of cervical cancer as a public health problem.

Primary prevention:

- Ensure sufficient HPV vaccines at an affordable price and increase their quality and coverage by introducing innovations to improve the efficiency of their administration
- Improve communication and social mobilization

Secondary prevention:

- Understand barriers to accessing services and create an enabling environment
- Integrate screening and treatment services into the primary care mix, promoting a screen-and-treat approach and ensuring the appropriate provision of quality, highly accurate screening tests and treatment devices.
- Strengthen laboratory capacity and quality assurance programs.

Treatment and palliative care:

- Implement cervical cancer treatment guidelines, strengthen pathology services, and expand surgical capacity and access to radiotherapy and chemotherapy.
- Strengthening palliative care and comprehensive support services to improve quality of life and address mental and sexual health challenges faced by survivors.

The Global Strategy proposes three targets to be achieved by 2030: 90% of girls vaccinated with HPV vaccine before turning 15 years; 70% of women screened with high-precision testing by age 35, and again by age 45; and 90% of women diagnosed with cervical cancer receive treatment.



People with disabilities

Nearly 12% of the population of Latin America and the Caribbean has at least one disability; that implies a total of about 66 million people.

The sexual and reproductive health of persons with disabilities is usually made invisible due to ignorance and discrimination, due to the erroneous assumption of their non-sexuality, and their lack of autonomy to decide about their bodies, their health, and their sexual and reproductive lives.

Persons with disabilities face additional barriers to access services, education, and information on sexual and reproductive health: inaccessibility of health facilities, communication challenges, health professionals lacking specific training, and financial limitations are some of the most frequent. They are more exposed to situations of gender-based violence and other forms of violence and abuse.

The Convention on the Rights of Persons with Disabilities (CRPD) recognizes these persons as subjects of rights, which implies their full recognition as sexed subjects, with functional diversity, with different ways of experiencing sexuality, with an active position and with the capacity to decide for themselves.

While progress has been made toward achieving the goals outlined in the *Plan of Action on Disability and Rehabilitation* developed by PAHO in 2020, with more countries having national disability legislation and plans, many of these plans have not been fully implemented and persons with disabilities continue to face significant barriers to accessing health care services in many countries.



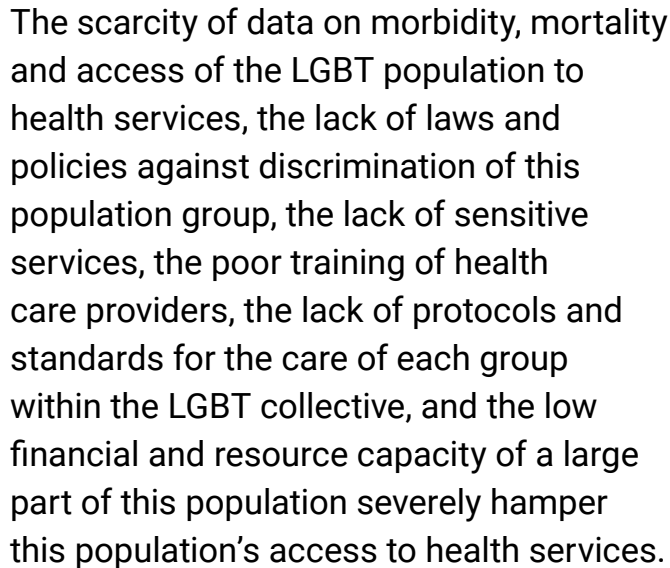
LGBT population

The LGBT population has worse health outcomes than the heterosexual population. In their sexual and reproductive health, they face problems such as lack of cancer screening, low visibility in comprehensive sexuality education (CSE), and a higher risk of violence, including child sexual abuse.

This population faces barriers to early and timely access to health services and even fails to access them, often because their confidentiality is not ensured, there is lack of privacy in care, and there is no person-centered health care.



Las personas LGBT con VIH que son altamente estigmatizadas tienen 2,4 veces más probabilidades de retrasar la búsqueda de atención médica y mayores problemas de salud mental.



The scarcity of data on morbidity, mortality and access of the LGBT population to health services, the lack of laws and policies against discrimination of this population group, the lack of sensitive services, the poor training of health care providers, the lack of protocols and standards for the care of each group within the LGBT collective, and the low financial and resource capacity of a large part of this population severely hamper this population's access to health services.

Stigmatization and discrimination by society and health systems against the LGBT population result in an inadequate understanding of their specific problems and the formation of prejudices about the causes of their illnesses. This results in refusal of care or inadequate or below-average care by health services.



The continued access barriers to health care faced by the LGBTQI+ population stem from stigma and discrimination in society, including from health systems. We need to continue to promote and protect the human rights of LGBTQI+ people.”

United States representative at the 60th Directing Council, 75th Session of the WHO Regional Committee for the Americas, held in Washington, D.C., USA, September 25-29, 2023.



Men's health

Male gender roles and socially imposed practices affect men's health in many aspects, leading to risk behaviours (lifestyles and behaviours) that result in greater access to health services for emergencies, with decompensated chronic conditions or due to external causes, and low utilization of control and prevention services.

Men have a higher premature mortality rate than women.
Lack of physical and mental health self-care negatively affects many men's life trajectory.

The health system addresses the consequences of hegemonic male socialization in a fragmented manner.

In the field of sexual and reproductive health, given the prevalence of a gender culture that conceives reproduction as an exclusively female phenomenon, men are not called upon to assume full co-responsibility for antenatal care, childbirth, breastfeeding, contraception, child care and domestic activities.

Some solutions to these problems are emerging from civil society and the academic sector, but there are still no organized programmatic responses that are sufficient, comprehensive and connected with other public policy sectors.

Policies should consider the discrepancies between men's health needs and their social behaviours through comprehensive and integrated, gender-sensitive and co-responsible approaches.



Call to action

The countries of the Americas region agreed on the terms of the document **“Status of Access to Sexual and Reproductive Health Services”**, which calls for a redoubling of efforts to expand access to sexual and reproductive health services, reduce inequities, guarantee human rights and contribute to universal coverage.

To advance towards the achievement of these objectives, the health authorities of PAHO Member States agreed on the following strategies and actions:

- Promote and implement comprehensive normative frameworks, policies and regulations that guarantee the exercise of sexual and reproductive rights and universal access to sexual and reproductive health services, without discrimination of any kind, to reduce inequalities, improve development opportunities for individuals and families, and advance in the effective fulfilment of the commitments assumed in this field.

Regulatory frameworks act not only as regulators of the institutional framework and practices of the health system; they also operate as more or less enabling scenarios for health services to respond appropriately to health and population needs. They can also generate opportunities and guide the behaviours of health agents towards person-centred care.

- Expand access to sexual and reproductive health services with a primary health care approach through:
 - ▶ The capacity and effectiveness of the first level of care in integrated health networks, ensuring comprehensive sexual and reproductive health services, applying an inclusive approach to health, sexuality and reproduction.
 - ▶ Community participation and intersectoral collaboration to reach groups in vulnerable situations.
 - ▶ Training of health teams around the perspective of equity, gender, and rights to ensure comprehensive sexual and reproductive health care.
 - ▶ Recovery of essential sexual and reproductive health services affected during the COVID-19 pandemic.
 - ▶ Use of the task-sharing model of care to expand the availability and accessibility of services and the implementation of innovations linked to digital health.

Most SRH services are provided at the first level of care, the gateway to the health system. Community participation and intersectoral actions are key to influence the multiple determinants of SRH problems. An appropriate and timely response by health services requires teams that are aware of the social determinants of SRH problems and willing to share tasks.

- Increase investment in sexual and reproductive health policies and programs. This provides has significant economic benefits for governments, societies and individuals. Ensure adequate and sustainable funding for the implementation of cost-effective evidence-based interventions, the organization and delivery of comprehensive sexual and reproductive health services, and access to universal and free sexual and reproductive health medicines.

Investing in proven interventions and providing free access to SRH supplies and medicines has significant returns for individuals, societies, and states by improving women's educational and employment development opportunities and saving state resources.

- Strengthen articulation, intersectoral work and care protocols between the areas of health, education, social protection, security, and justice to implement comprehensive policies and programs to intervene on the determinants of sexual and reproductive health, and to respond to violations of sexual and reproductive rights, with particular emphasis on CSE.


The determinants of SRH are multiple; a comprehensive approach to the problems requires coordinated sectoral interventions, as recommended by the evidence available. The scenario is particularly enabling because there is evidence on what needs to be done and how to do it: good SRH practices are available and should be promoted, adapting them to the specific contexts.

- Strengthen research and information systems for the collection and analysis of sexual and reproductive health indicators disaggregated by age, gender (including LGBT diversity), ethno-racial affiliation and place of residence, to determine equity gaps, and inform the monitoring and evaluation of sexual and reproductive health policies and programs and the local evidence needed to contextualize actions, under a legal framework that favours the integration and legal protection of data.

The design, implementation and evaluation of policies require relevant and timely information. The production, systematization, analysis and generation of decision-oriented information systems and tools is key to all stages of the health policy cycle.

- Increase political commitment to improve the coverage and effectiveness of sexual and reproductive health policies and programs, setting short- and medium-term targets, accountability mechanisms, and opportunities for the participation of the groups affected.

The possibilities of a health policy to succeed are strongly conditioned by its political endorsement by the authorities at all levels of the health system. It is also conditioned by its capacity to establish explicit goals and to generate institutions and mechanisms to account for its progress and to have the input and oversight of the groups affected.



This brief presents the guidelines and agreements in the information document Status of access to sexual and reproductive health services, prepared by the Pan American Health Organization (PAHO) at the request of its Member States at the 30th Pan American Sanitary Conference. It was presented and unanimously approved by the countries of the Region of the Americas at the 60th Meeting of the Directing Council, 75th session of the WHO Regional Committee for the Americas, held in Washington, D.C., USA, September 25-29, 2023. Its objective is to describe the status of access to sexual and reproductive health services in the Americas region, identify health responses and barriers to access, and suggest recommendations for countries. It was developed based on a review and systematization of data, plans and initiatives, scientific papers, United Nations reports, and legal and regulatory frameworks on sexual and reproductive health.