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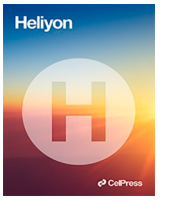

Review article

Autonomy and freedom of choice: A mixed methods analysis of the endorsement of SRHR and its core principles by global agencies

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ABSTRACT

Based on an adapted version of the conceptual framework used by the Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights (SRHR), this study sought to analyse to what extent seven global agencies, five of which belong to the UN family and the other two closely linked, incorporate women's autonomy and freedom of choice in accessing services into their SRHR policies, and how they operationalize these in their global SRHR programmes that target women and adolescent girls. Twenty-nine SRHR-related policy documents published in 2013–2020 and 17 independent evaluations of global SRHR programmes in the same period were analysed. They were found to fall short of considering women's individual autonomy and choice as the two core principles of SRHR. By ignoring autonomy and choice, global SRHR programmes missed the opportunity to incorporate activities that could enhance the emancipatory empowerment of women and girls to improve their sexual and reproductive wellbeing. The study identified concrete aspects on which global agencies, in view of their respective mandates, could have pronounced themselves more explicitly and might have been more effective in implementing SRHR programmes. In light of the international gender equality and women's empowerment discourse this suggests that donor countries could hold global agencies more accountable, bilaterally or jointly, for their SRHR performance, in particular their active endorsement and application of SRHR core principles.

Key messages

What is already known on this topic.

Disparities in access to sexual and reproductive health services have been studied extensively in low- and middle-income countries, including barriers to expanding the coverage of in particular maternal and newborn health, contraception and HIV services, and how such barriers could be overcome so as to improve health outcomes among vulnerable populations.

What this study adds.

This is the first study that analyses how multilateral organisations and international agencies view individual autonomy and freedom of choice in accessing SRHR services, and examines the extent to which they incorporate these core principles in their SRHR policies and implement them in their global programmes.

How this study might affect research, practice or policy.

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Real progress towards universal SRHR coverage and the achievement of SRHR targets requires the full embracement of SRHR in all its dimensions. This would imply a much more explicit and active endorsement of individual autonomy and freedom of choice as core principles, and refraining from the silencing of women's agency.

1. Introduction

Whereas the 4th International Conference on Population and Development (ICPD) held in Cairo (1994) marked a fundamental shift in focus from population control and family planning towards comprehensive reproductive and sexual needs and rights of individuals [1], the global family planning platform FP2020, established in 2012, refocussed on family planning as a single issue [2]. Some scholars view this as a reversal of past gains and testimony of a technocratic approach to reproductive health, reinvigorating vertical programming and standing in the way of an integrated approach to promote sexual and reproductive health and rights (SRHR) [3]. It would induce a bifurcation of SRHR into sexual and reproductive health as two separate concepts, and the isolation of sexual rights from reproductive rights [4]. In 2017, the then new US government re-installed the Mexico City Policy, dubbed by its critics as the Global Gag Rule, to halt all USA financial support for organisations that support SRHR, especially access to comprehensive sexuality education, contraception for young unmarried people and safe abortion [5].

Women's interest groups have repeatedly advocated for more open communication and called for acceptance of women's sexual and reproductive rights [6–10]. Some have claimed these calls have largely fallen on deaf ears in donor agencies and international organisations, for example when it comes to the rights of women and girls living with HIV [11]. Starting in the 1980s, much analytical work on women's and children's sexual and reproductive rights, women's autonomy and women's agency has been done and continues to be done [12–14].

European governments frequently made diplomatic statements on SRHR. In 2019, for example, the Dutch government delivered a statement on universal health coverage (UHC) of SRHR services, emphasizing the need for gender equity and for increasing women's bodily autonomy [15]. Prior to that, and directly in response to the Global Gag Rule, the Dutch Minister of Foreign Trade and International Development initiated a movement by the name of *SheDecides* to raise financial and political support for SRHR worldwide, focussing on bodily autonomy for girls and women [16]. In 2020, the Danish Minister of Equal Opportunities delivered a diplomatic statement reaffirming the importance of SRHR as part of the Beijing Declaration [17], and supporting women's full autonomy. The governments of these two countries advocate gender equity and the rights of all women and girls to make their own decisions concerning their bodies and lives; and in doing so they embrace the fundamentals of SRHR. An incident of global significance in India, in 2012, was the so-called Nirbhaya gang-rape case in New Delhi, causing widespread outrage and giving rise to activism against sexual violence on several fronts and in various platforms. In 2017, the Twitter hashtag #MeToo went viral, with thousands of women sharing their personal experiences of sexual assault and abuse [18]. Coincidentally, the 2018 report of the authoritative Guttmacher-Lancet Commission (GLCo) on Sexual and Reproductive Health and Rights presented a conceptual framework, repeating earlier calls for an integrated definition of SRHR and reinforcing the fundamentals of SRHR [4]. These fundamentals date back to the 1994 ICPD programme of action, adopted by 179 governments, which called for gender equality and women's empowerment to take centre stage in national and global development efforts [19].

The GLCo framework on SRHR is schematically composed of seven components, various target groups, each with their distinct SRHR needs, and four implementation approaches (service provision, education, counselling, information), all underpinned by two principles, namely that of autonomy and choice in accessing services [4]. The GLCo describes in detail the nature and significance of each of the seven SRHR components: Gender-based violence (GBV), HIV/AIDS and other sexually transmitted infections (STI), Contraception, Maternal & newborn health, Abortion, Infertility, and Reproductive cancers. They are highly interrelated, pronouncing a holistic view of SRHR that brings together people's health and sexuality, without dissociating them from human rights issues.

The commission positions 'autonomy' of individuals in the context of SRHR and 'choice in accessing services' as a type of freedom and an entitlement enshrined in human rights. Adherence to these two principles is not to be taken for granted in many, if not all societies, especially when it comes to adolescent girls and adult women [20,21]. The GLCo states that *"although the (SRHR) definition applies to everyone, the issues are especially relevant for women because of biological factors and because of socially defined gender roles that discriminate against them"* [4]. One can advance that there are structural determinants both within and outside health systems, such as power dynamics and gender norms, that may influence individual autonomy and freedom of choice, but these are often not acknowledged.

If viewed primarily as 'bodily autonomy', a term also used by the GLCo, autonomy in the context of SRHR can be defined as an individual's legal and practical capacity to make choices about what happens to their body without interference from others. Implicit in bodily autonomy is the notion of agency: an autonomous woman is an actor – not merely a person acted upon – in her family, in her wider social groups, in economic life, and in the political arena [22]. Freedom of choice refers to individuals' right to voluntary and independently make their own decisions [23]. Fulfilling these rights in SRHR programmes, as also stated by the GLCo, "takes place in a broader social, economic, cultural and health care context" [4]. This implies that, while SRHR programmes and services themselves may be expected to promote agency and autonomy, harmful gender norms may be replicated within health policies and amongst health workers, resulting in services that negatively affect equitable access and individual autonomy.

Progress in SRHR is not automatic, partly because of sensitivities around women's rights and gender norms [24]. It has actually been slow in many parts of the world, especially in low- and middle-income countries (LMIC) [4], and this is often attributed to a lack of political will in those countries [25]. The international political will of global agencies to advance a comprehensive SRHR agenda, however, is rarely questioned, although there have been regressions in SRHR language. Global agencies have to somehow deal with the often polarized context of SRHR in many countries, especially around sexual rights and gender issues [26,27]. Although this is widely

known, the implications are not necessarily sufficiently acknowledged. This article analyses how international organisations define SRHR in their policies, how they operationalize SRHR in their global programmes, and whether this, according to external evaluations and reviews, can be positioned as good examples or catalysts for positive change to advance women's health. The study explores to what extent the fundamentals of SRHR are supported at the global level, and which policy positions multilateral organisations and international agencies adopt, in particular those that receive official development assistance (ODA) from European bilateral donors for SRHR.

All global agencies of interest in this paper have wider mandates than SRHR or even health. They receive funding from several European governments, among others, who jointly affirmed their commitment to provide "*strong political and* financial support *to complete the unfinished business of the ICPD Programme of Action*" [28], in line with ICPD (1994) and the ICPD+25 (2019) commitments to ensure that the 2030 Agenda is achieved, and women have autonomy over their bodies and their lives [26]. Also worth mentioning is Countdown 2030 Europe, a consortium of 15 leading European non-governmental organisations that attempt to ensure worldwide advancement of human rights and investment in family planning [28]. They do this by holding their respective governments to account for their policy and funding commitments to achieve universal access to reproductive health, and address the unmet need for contraception. The Countdown 2030 Europe database contains SRHR profiles of twelve donor countries, stating which international organisations they support, technically and/or financially [29]. Each country SRHR profile lists one or more of the seven global agencies that are reviewed in this article.

1.1. Research question

The main research question was: to what extent do multilateral organisations and international agencies, in view of their respective official mandates, incorporate the two principles of autonomy and freedom of choice in accessing services into their SRHR policies, and how do they operationalize these in their global SRHR programmes that target women and adolescent girls.

2. Methods

The study object comprised seven global agencies that receive ODA from European donor countries for SRHR: five multilateral organisations that form part of the United Nations family (UNFPA, WHO, UNAIDS, UNICEF and UN Women); and two international funding agencies (the Global Fund for AIDS, Malaria and Tuberculosis, GFATM; and the Global Financing Facility, GFF, which is part of the World Bank Group). For ease of language this paper will use the generic term 'global agencies' to refer to both types of organisations.

3. Conceptual framework

The conceptual framework (Fig. 1), adapted from GLCo's SRHR framework, served as the basis for analysis, in particular its premise that autonomy and (freedom of) choice constitute two core principles. They are not to be conflated, as autonomy in the context of SRHR refers to agency and control over what happens to one's own body, whereas freedom of choice refers to the extent to which an individual is able to choose herself from a range of options, which may or may not be easily attainable. Choice can be health service provider-driven, in which case a range of barriers and enablers come into play, including service quality, that codetermine whether or not potential clients actually access services that are on offer. Autonomy is largely determined by sociocultural factors in society in general, which may also affect how SRHR services are delivered. For example, the way health workers provide support to clients suffering from sexual abuse is influenced by social norms and values [30]. The analysis distinguishes between the seven SRHR components, as per the GLCo framework; and it decomposes SRHR into its four constituent elements: sexual health, reproductive health, sexual rights and reproductive rights.

The seven global agencies were initially subjected to an analysis of their policy documents and strategic plans; in the second

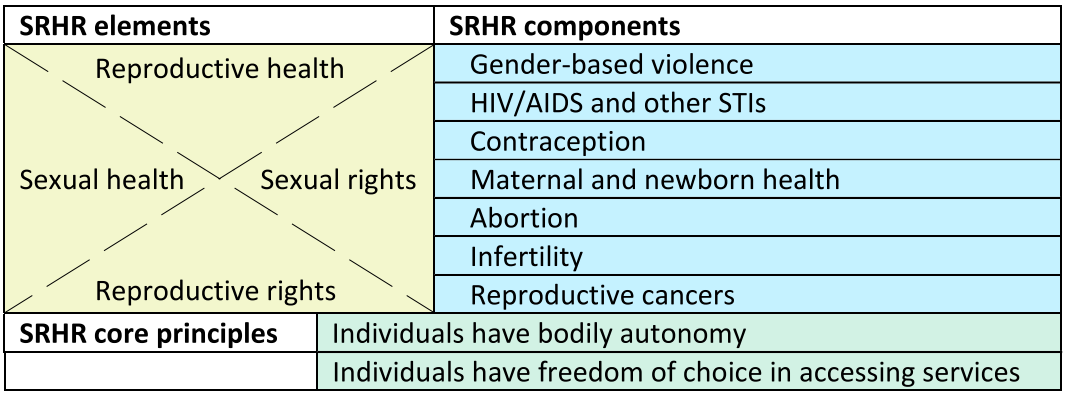

Fig. 1. Conceptual framework of SRHR, adapted from the GLCo's framework 'Components of SRHR and populations in need' [4].

instance external evaluations of their global programmes were identified and analysed, based on the conceptual framework and with the GLCo report as a reference. Although this report was published in 2018, at a time when several of the global agencies' current policies and ongoing programmes had already been formulated, it basically brought together concepts, principles and approaches that had been internationally agreed upon much earlier. We therefore considered it justifiable to take the period 2012 to 2020 as the review period, whereby 2012 was chosen for pragmatic reasons.

3.1. Policy analysis

SRHR-related policy documents and strategic plans of the seven global agencies were identified from their respective websites and related to the agencies' corporate mandates and ambitions. Next, it was examined how each agency defines and conceptualises SRHR, in particular whether they separate sexual from reproductive health or see them as interlinked; whether they consider women's rights at all, including sexual rights; and whether they address the core principles of SRHR, i.e. women's individual autonomy (or bodily autonomy) and freedom of choice.

3.2. Review of global SRHR programmes and associated reviews and evaluations

With regard to practices, the global SRHR programmes undertaken by the seven global agencies were identified, along with all external global programme evaluations or reviews performed since 2012 that were published in the form of publicly available reports or journal articles. Programme reviews, annual reports and donor reports written by the agencies themselves were excluded, as these cannot be considered independent. Evaluations, reviews and research articles were identified from the database of the United Nations Evaluation Group and the websites of the seven global agencies themselves. This was complemented by a systematic search in PubMed, performed on August 19, 2020, based on a detailed search string and additional snowballing to identify articles published between January 2013 and August 2020. Supplementary file 1 describes the method used for this literature search and review, including the search terms, delineation, the inclusion and exclusion criteria, and the process of screening, data extraction, charting and analysis. Fig. 2 provides a flow diagram of the screening and selection process according to PRISMA guidelines.

The precise strategies through which each global agency covers one or more constituent elements of SRHR, one or more of its components or how they link these to SRHR principles were not analysed. The focus was rather on whether the various global agencies that address SRHR refer in any way to its two fundamental principles, i.e. personal autonomy and freedom of choice.

3.3. Frequency counts and qualitative analysis

The identified policy documents, global programmes and evaluations/reviews were initially subjected to digital frequency counts of SRHR key terms, followed by a combination of thematic and discourse analyses. Frequency analysis of key terms is an established method to reveal the often hidden values, views and assumptions that underly strategic policy choices [31]. The frequency counts performed in this study are in relation to the separate SRHR elements (sexual health, reproductive health, sexual rights, and reproductive rights) and SRHR as an integrated concept, the two core principles of SRHR (autonomy and freedom of choice) and its seven components. Thematic analysis was then performed, based on the above themes (SRHR key terms, elements, core principles, components), taking into account the specific mandates of the respective global agencies and the contexts in which they operate. This was then followed by a discourse analysis specifically on the two core principles (autonomy and freedom of choice). The latter principles typically originate from the field of women's movements, reason for which the discourse analysis mainly drew from this body of literature [32–34].

3.4. Patient and public involvement

Involvement of clients of SRHR services or the general public was not considered applicable in any stage of this study. The study results have not yet been disseminated through other channels. The intention is to share this article, once peer-reviewed and published, with global agencies, the SRHR donor community and women's movement organisations.

4. Results

Twenty-nine SRHR-related policy documents (listed in Table 1) were identified for the review period and 23 global programmes (Table 2) with their respective external evaluations and reviews, of which there were 17 in total (two evaluations/reviews were for the same programme; seven programmes had no evaluation/review). The evaluations appeared in eleven publicly available evaluation reports, and seven peer-reviewed journal articles.

The results of the policy analysis are described below, followed by the programme analysis results.

4.1. Policy analysis

Table 1 provides an overview of the SRHR-related policies of each of the seven global agencies, describing their mandates and showing the frequency counts of the following dimensions.

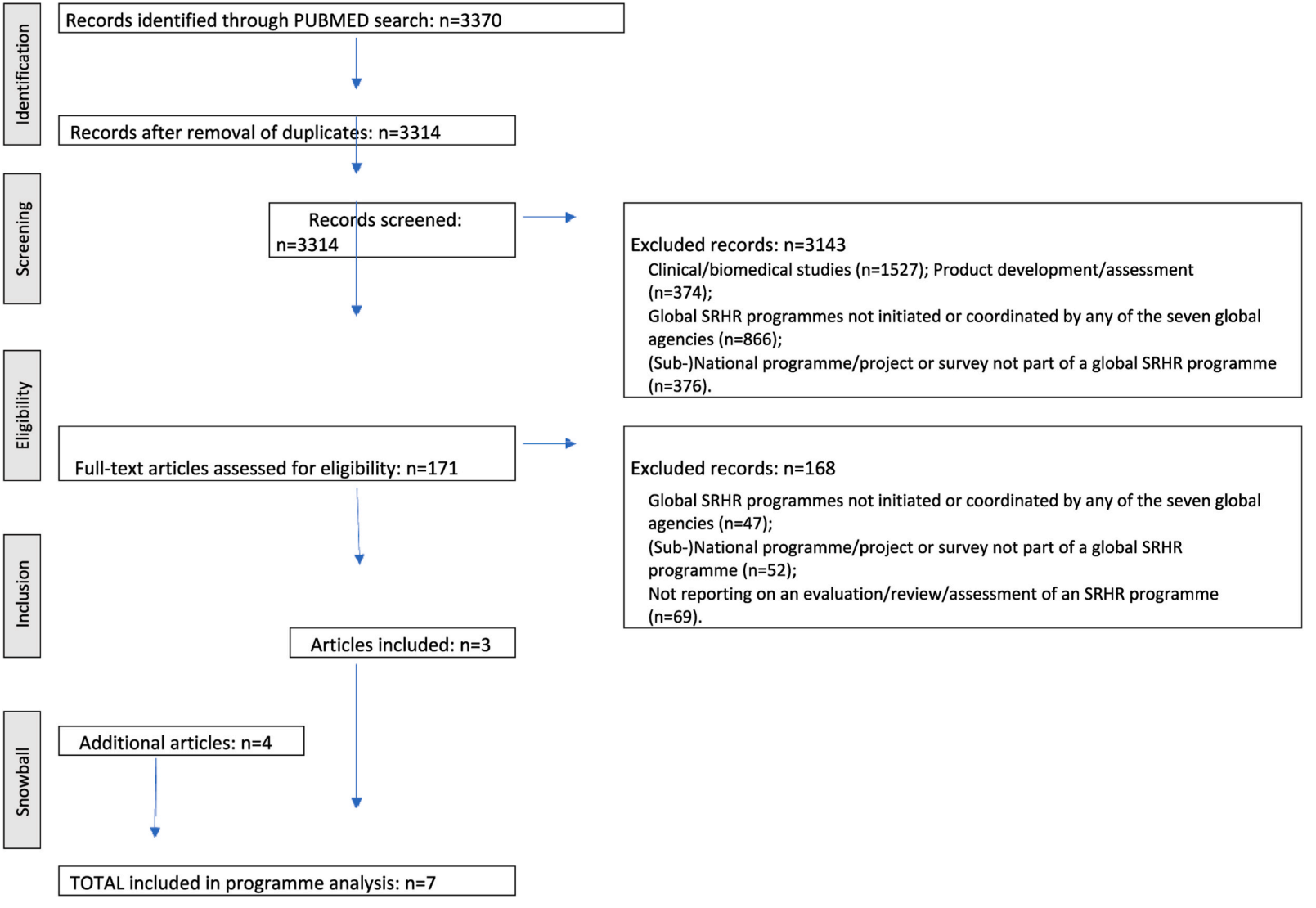

Fig. 2. Flowchart of the screening and selection process of publications on SRHR global programmes as per PRISMA guidelines.

Table 1
Conceptualisation of SRHR in policy documents and strategic plans of seven global agencies: mandates, SRHR elements, SRHR core principles and SRHR components (with frequency counts in brackets).

Policy documents and strategic plans	SRHR elements	SRHR core principles	SRHR components						
	SRHR, SRH, SRR, Reprod Rights (RR), Sexual Rights (SR)	Autonomy, Choice	Gender-based violence (GBV), Violence against women (VAW), Sexual violence (SV)	HIV/AIDS and other STI	Contraception/ contraceptive, Family planning/FP	Maternal & newborn health (M&NH), Maternal health (MH), Newborn health (NH)	Abortion, post-abortion	Infertility	Reproductive cancer, Cervical cancer
UNFPA – UNFPA's mandate is (1) to build the knowledge and the capacity to respond to needs in population and family planning; (2) to promote awareness in both developed and developing countries of population problems and possible strategies to deal with these problems; (3) to assist their population problems in the forms and means best suited to the individual countries' needs; (4) to assume a leading role in the United Nations system in promoting population programmes, and to coordinate projects supported by the Fund. (UNFPA was given the lead in helping countries carry out the Programme of Action at the Cairo Conference. In 2010, the United Nations General Assembly extended the ICPD beyond 2014, which was initially meant to be the final year of the 20-year Programme of Action)									
UNFPA Strategy on Adolescents and Youth – Towards realizing the full potential of adolescents and youth (2012–2015). https://www.unfpa.org/sites/default/files/resource-pdf/UNFPA%20Adolescents%20and%20Youth%20Strategy.pdf	SRHR (6x); SRH (18x); SRR (–); RR (–); SR (–)	Autonomy (–); Choice (2x)	GBV (–); VAW (–); SV (1x)	AIDS (5); HIV (24x); HIV/AIDS (5x); STI (2x)	Contracepti* (2x); FP (4x)	M&NH (–); MH (2x); NH (–)	Abortion (5x); post-abortion (1x)	–	–
UNFPA Strategic Plan 2018–2021. DP.FPA_.2017.9_-_UNFPA_strategic_plan_2018–2021_-_FINAL_-_25July2017_-_corrected_24Aug17.pdf	SRHR (2x); SRH (39x); SRR (1x); RR (24x); SR (–)	Autonomy (1x); Choice (1x)	GBV (17x); VAW (1x); SV (2x)	AIDS (2x); HIV (13x); HIV/AIDS (1x); STI (1x)	Contracepti* (1x); FP (9x)	M&NH (–); MH (2x); NH (–)	–	–	–
Common chapter in the respective strategies (2018–2021) of UNDP, UNICEF, UNFPA, and UN Women. https://www.unfpa.org/sites/default/files/board-documents/DP.FPA_.2020.4_Part_I_-_Common_Chapter_annex_2019_-_FINAL_-_12May20.pdf	SRHR (1x); SRH (10x); SRR (–); RR (11x); SR (–)	Autonomy (–); Choice (1x)	GBV (12x); VAW (14x); SV (2x)	AIDS (13x); HIV (14x); HIV/AIDS (4x); STI (1x)	Contracepti* (–); FP (2x)	M&NH (–); MH (8x); NH (–)	–	–	–
UNFPA Business Plan: The Maternal and Newborn Health Thematic Fund (Business plan phase 3, 2018–2022). https://www.unfpa.org/publications/business-plan-maternal-and-newborn-health-thematic-fund	SRHR (33x); SRH (106x); SRR (6x); RR (7x); SR (–)	–	GBV (5x); VAW (–); SV (–)	AIDS (4x); HIV (14x); HIV/AIDS (1x); STI (2x)	Contracepti* (17x); FP (25x)	M&NH (114x); MH (29x); NH (2x)	Abortion (43x); post-abortion (18x)	Infertility (1x)	Reprod cancer (–); Cervical cancer (22x)
Rights and choices for all adolescents and youth: a UNFPA global strategy. "MY BODY, MY LIFE, MY WORLD!" 2019. https://www.unfpa.org/youthstrategy	SRHR (7x); SRH (9x); SRR (–); RR (2x); SR (–)	Autonomy (2x); Choice (31x)	GBV (5x); VAW (–); SV (0x)	AIDS (–); HIV (1x); HIV/AIDS (–); STI (1x)	Contracepti* (1x); FP (2x)	–	Abortion (1x)	–	–
WHO – WHO's mandate is to advocate for universal healthcare, monitor public health risks, coordinate responses to health emergencies, and promote human health and wellbeing, establish, monitor and enforce international norms and standards, and coordinating multiple actors toward common goals.									

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Table 1 (*continued*)

Policy documents and strategic plans	SRHR elements	SRHR core principles	SRHR components						
	SRHR, SRH, SRR, Reprod Rights (RR), Sexual Rights (SR)	Autonomy, Choice	Gender-based violence (GBV), Violence against women (VAW), Sexual violence (SV)	HIV/AIDS and other STI	Contraception/ contraceptive, Family planning/FP	Maternal & newborn health (M&NH), Maternal health (MH), Newborn health (NH)	Abortion, post-abortion	Infertility	Reproductive cancer, Cervical cancer
WHO Sexual and reproductive health – Medium-term strategic plan (2010–2015). WHO_RHR_11.07_eng.pdf	SRHR (4x); SRH (452x); SRR (−); RR (12x); SR (−)	Autonomy (−); Choice (5x)	GBV (4x); VAW (16x); SV (9x)	AIDS (18x); HIV (166x); HIV/AIDS (20x); STI (12x);	Contracepti* (71x); FP (95x)	M&NH (13x); MH (8x); NH (1x)	Abortion (154x); post-abortion (8x)	Infertility (34x)	Reprod cancer (−); Cervical cancer (33x)
Global Health Sector strategy on Sexually Transmitted Infections 2016–2021 – Towards Ending STI's, 2016. https://apps.who.int/iris/bitstream/handle/10665/246296/WHO-RHR-16.09-eng.pdf;sequence=1	SRHR (1x); SRH (13x); SRR (−); RR (−); SR (−)	Autonomy (−); Choice (1x)	GBV (2x); VAW (2x); SV (2x)	AIDS (9x); HIV (82x); HIV/AIDS (2x); STI (189x)	Contracepti* (−); FP (7x)	–	–	Infertility (4x)	Reprod cancer (−); Cervical cancer (12x)
Global Health sector strategy on HIV 2016–2021. Towards ending AIDS. June 2016. https://www.who.int/publications-detail-redirect/9789241511537	SRHR (−); SRH (6x); SRR (−); RR (−); SR (−)	–	GBV (4x); VAW (−); SV (4x)	AIDS (97x); HIV (645x); HIV/AIDS (6x); STI (9x)	–	–	–	–	Reprod cancer (−); Cervical cancer (1x)
WHO. Global Plan of Action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence (2016). https://www.who.int/publications-detail-redirect/9789241511537	SRHR (−); SRH (35x); SRR (−); RR (5x); SR (−)	Autonomy (2x); Choice (−)	GBV (6x); VAW (138x); SV (53x)	AIDS (7x); HIV (14x); HIV/AIDS (2x); STI (2x)	Contracepti* (3x); FP (3x)	M&NH (1x); MH (−); NH (−)	Abortion (5x); post-abortion (−)	–	–
Every woman, every child. Global Strategy for Women's, Children's and Adolescents' Health (2016–2030): Survive, thrive, transform. https://www.who.int/docs/default-source/child-health/the-global-strategy-for-women-s-children-s-and-adolescents-health-2016-2030.pdf	SRHR (1x); SRH (8x); SRR (−); RR (−); SR (−)	Autonomy (−); Choice (4x)	GBV (8x); VAW (3x); SV (4x)	AIDS (7x); HIV (14x); HIV/AIDS (3x); STI (1x)	Contracepti* (8x); FP (6x)	M&NH (1x); MH (1x); NH (−)	Abortion (4x); post-abortion (2x)	–	Reprod cancer (−); Cervical cancer (2x)
UNAIDS – UNAIDS's mandate is to provide global leadership in response to the HIV/AIDS epidemic; to provide means of coordinated action of the UN system (co-sponsors) on policy and programmatic approaches; to monitor trends and ensure that appropriate as well as effective policies and strategies are implemented at country level; to strengthen the capacity of national Governments to develop comprehensive national strategies, and implement effective HIV/AIDS activities at country level; in 2018 UNAIDS reiterated its strong commitment to the mandate of UNAIDS towards ending the AIDS epidemic by 2030.									
UNAIDS Global Plan towards the elimination of new HIV infections among children by 2015 and keeping the mothers alive 2011–2015. https://www.unaids.org/en/resources/documents/2011/20110609_JC2137_Global-Plan-Elimination-HIV-Children_en.pdf	SRHR (−); SRH (1x); SRR (−); RR (−); SR (−)	–	GBV (1x); VAW (−); SV (−)	AIDS (34x); HIV (358x); HIV/AIDS (6x); STI (−)	Contracepti* (1x); FP (23x)	M&NH (−); MH (6x); NH (−)	–	–	–

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Table 1 (*continued*)

Policy documents and strategic plans	SRHR elements	SRHR core principles	SRHR components						
	SRHR, SRH, SRR, Reprod Rights (RR), Sexual Rights (SR)	Autonomy, Choice	Gender-based violence (GBV), Violence against women (VAW), Sexual violence (SV)	HIV/AIDS and other STI	Contraception/ contraceptive, Family planning/FP	Maternal & newborn health (M&NH), Maternal health (MH), Newborn health (NH)	Abortion, post-abortion	Infertility	Reproductive cancer, Cervical cancer
UNAIDS Strategy 2016–2021: on the fast track to end AIDS. https://www.unaids.org/en/resources/documents/2015/UNAIDS_PCB37_15-18	SRHR (8x); SRH (33x); SRR (−); RR (−); SR (−)	Autonomy (10x); Choice (4x)	GBV (13x); VAW (5x); SV (5x)	AIDS (655x); HIV (880x); HIV/AIDS (8x); STI (7x);	Contracepti* (4x); FP (5x)	–	–	–	Reprod cancer (−); Cervical cancer (3x)
UNAIDS. Cities ending the AIDS epidemic, 2016. https://www.unaids.org/sites/default/files/media_asset/JC2871_citiesmeetingreport_en.pdf	SRHR (−); SRH (8x); SRR (−); RR (−); SR (−)	–	GBV (2x); VAW (−); SV (11x)	AIDS (251x); HIV (584x); HIV/AIDS (16x); STI (11x)	Contracepti* (1x); FP (2x)	–	–	–	–
UNAIDS. Knowledge is power. Know your status, know your viral load, 2018. https://www.unaids.org/en/resources/documents/2018/knowledge-is-power-report	–	Autonomy (2x); Choice (4x)	GBV (1x); VAW (−); SV (−)	AIDS (59x); HIV (695x); HIV/AIDS (2x); STI (3x); STI/ HIV (1x)	Contracepti* (−); FP (1x)	–	–	–	–
UNAIDS Policy brief. Actions for improved clinical and prevention services and choices preventing HIV and other sexually transmitted infections among women and girls using contraceptive services in contexts with high HIV incidence, 2020. https://www.unaids.org/sites/default/files/media_asset/preventing-hiv-sti-among-women-girls-using-contraceptive-services_en.pdf	SRHR (4x); SRH (3x); SRR (−); RR (−); SR (−)	Autonomy (−); Choice (27x)	GBV (2x); VAW (−) SV (−)	AIDS (17x); HIV (237x); HIV/AIDS (4x); STI (14x)	Contracepti* (104x); FP (3x)	–	–	Infertility (1x)	–
UNICEF – UNICEF's mandate is to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. UNICEF is guided by the Convention on the Rights of the Child and strives to establish children's rights as enduring ethical principles and international standards of behaviour towards children. UNICEF insists that the survival, protection and development of children are universal development imperatives that are integral to human progress.									
UNICEF HIV/AIDS programme: vision and direction for action, achieving an AIDS free generation (2014) https://www.unicef.org/media/50736/file/2014_Annual_Results_Report_HIV_and_AIDS.pdf	SRHR (−); SRH (1x); SRR (−); RR (−); SR (−)	–	GBV (5x); VAW (−); SV (−)	AIDS (142x); HIV (263x); HIV/AIDS	Contracepti* (−); FP (2x)	M&NH (−); MH (3x); NH (−)	–	–	–

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Table 1 (*continued*)

Policy documents and strategic plans	SRHR elements	SRHR core principles	SRHR components						
	SRHR, SRH, SRR, Reprod Rights (RR), Sexual Rights (SR)	Autonomy, Choice	Gender-based violence (GBV), Violence against women (VAW), Sexual violence (SV)	HIV/AIDS and other STI	Contraception/ contraceptive, Family planning/FP	Maternal & newborn health (M&NH), Maternal health (MH), Newborn health (NH)	Abortion, post-abortion	Infertility	Reproductive cancer, Cervical cancer
				(32x); STI (–)					
UNICEF Strategic Plan 2018–2021. https://www.unicef.org/media/48126/file/UNICEF_Strategic_Plan_2018-2021-ENG.pdf	–	Autonomy (–); Choice (1x)	GBV (2x); VAW (0x); SV (2x)	AIDS (–); HIV (1x); HIV/AIDS (–); STI (–)	–	M&NH (–); MH (2x); NH (–)	–	–	–
Common chapter in the respective strategies (2018–2021) of UNDP, UNICEF, UNFPA, and UN Women. https://www.unicef.org/executiveboard/media/5326/file/2021_AS-Common_Chapter_SP-Joint_annex-EN-2021.05.05.pdf	SRHR (1x); SRH (10x); SRR (–); RR (11x); SR (–)	Autonomy (–); Choice (1x)	GBV (12x); VAW (14x); SV (2x)	AIDS (13x); HIV (14x); HIV/AIDS (4x); STI (1x)	Contracepti* (–); FP (2x)	M&NH (–); MH (8x); NH (–)	–	–	–
UNICEF. Strategy for health 2016–2030. August 2016. https://www.unicef.org/media/58166/file	SRHR (–); SRH (1x); SRR (–); RR (–); SR (–)	–	GBV (1x); VAW (–); SV (–)	AIDS (4x); HIV (15x); HIV/AIDS (1x); STI (1x)	–	M&NH (–); MH (1x); NH (2x)	–	–	–
UNICEF. Every child learns – Education strategy 2019–2030. https://www.unicef.org/reports/UNICEF-education-strategy-2019-2030	SRHR (1x); SRH (–); SRR (–); RR (–); SR (–)	Autonomy (–); Choice (2x)	GBV (5x); VAW (–); SV (1x)	AIDS (2x); HIV (5x); HIV/AIDS (3x); STI (1x)	–	–	–	–	–
UN Women – UN Women's mandate is to support inter-governmental bodies, such as the Commission on the Status of Women, in their formulation of policies, global standards and norms; to help Member States to implement these standards, standing ready to provide suitable technical and financial support to those countries that request it, and to forge effective partnerships with civil society; to hold the UN system accountable for its own commitments on gender equality, including regular monitoring of system-wide progress.									
UN Women. Policy brief 1: Making national social protection floors work for women, 2015. https://www.unwomen.org/en/digital-library/publications/2015/12/making-social-protection-floors-work-for-women	SRHR (–); SRH (1x); SRR (–); RR (–); SR (–)	Autonomy (1x); Choice (1x)	GBV (1x); VAW (–); SV (–)	AIDS (–); HIV (1x); HIV/AIDS (–); STI (–)	Contracepti* (–); FP (2x)	–	–	–	–
UN Women. Policy brief 5: Redistributing unpaid care and sustaining quality care services. A prerequisite for gender equality, 2015. https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2016/UN-Women-Policy-brief-05-Redistributing-unpaid-care-en.pdf	–	–	–	–	–	–	–	–	–

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Table 1 (*continued*)

Policy documents and strategic plans	SRHR elements	SRHR core principles	SRHR components						
	SRHR, SRH, SRR, Reprod Rights (RR), Sexual Rights (SR)	Autonomy, Choice	Gender-based violence (GBV), Violence against women (VAW), Sexual violence (SV)	HIV/AIDS and other STI	Contraception/ contraceptive, Family planning/FP	Maternal & newborn health (M&NH), Maternal health (MH), Newborn health (NH)	Abortion, post-abortion	Infertility	Reproductive cancer, Cervical cancer
UN Women. Strategic Plan 2018–2021. https://www.unwomen.org/en/digital-library/publications/2017/8/un-women-strategic-plan-2018-2021	SRHR (−); SRH (5x); SRR (−); RR (4x); SR (−)	Autonomy (2x); Choice (1x)	GBV (2x); VAW (9x); SV (−)	AIDS (2x); HIV (3x); HIV/AIDS (1x); STI (−);	–	M&NH (−); MH (1x); NH (−)	–	–	–
Common chapter in the respective strategies (2018–2021) of UNDP, UNICEF, UNFPA, and UN Women. 2017. https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Executive%20Board/2020/Second%20Regular%20Session/Background%20Doc%20ExB_Common%20Chapter_FINAL%20v2.pdf	SRHR (1x); SRH (10x); SRR (−); RR (11x); SR (−)	Autonomy (−); Choice (1x)	GBV (12x); VAW (14x); SV (2x)	AIDS (13x); HIV (14x); HIV/AIDS (4x); STI (1x)	Contracepti* (−); FP (2x)	M&NH (−); MH (8x); NH (−)	–	–	–
UN Women. Gender mainstreaming: global strategy for achieving gender equality and the empowerment of women and girls, 2020. https://www.unwomen.org/en/digital-library/publications/2020/04/brochure-gender-mainstreaming-strategy-for-achieving-gender-equality-and-empowerment-of-women-girls	–	Autonomy (−); Choice (1x)	GBV(−); VAW (1x); SV (2x)	–	–	–	–	–	–
Global Fund for AIDS, Tuberculosis and Malaria – GFATM's mandate is to accelerate progress against HIV, TB and malaria and improve global health.									
GFTATM: The Global Fund Strategy 2012–2016, Investing for impact. https://www.theglobalfund.org/media/1179/core_globalfundstrategy2012-2016_strategy_en.pdf	–	Autonomy (−); Choice (2x)	–	AIDS (12); HIV (9); HIV/AIDS (15x); STI (−)	–	M&NH (1x); MH (1x); NH (−)	–	–	–
GFATM: Strategy 2017–2022, Investing to end epidemics. https://www.theglobalfund.org/media/2531/core_globalfundstrategy2017-2022_strategy_en.pdf	SRHR (1x); SRH (1x); SRR (−); RR (−); SR (−)	Autonomy (−); Choice (1x)	GBV (4x); VAW (−); SV (−)	AIDS (19x); HIV (77x); HIV/AIDS (1x); STI (−)	–	–	–	–	–
Global Financing Facility – GFF's mandate is to support low and lower-middle income countries with catalytic financing and technical assistance to develop and implement prioritized national health plans to scale up access to affordable, quality care for women, children and adolescents.									
GFF concept note: GFF in support of every woman, every child. September 25, 2014 https://www.worldbank.org/content/dam/Worldbank/document/HDN/Health/ConceptNote-AGlobalFinancingFacilitySupportEveryWomanEveryChild.pdf	–	–	–	AIDS (3x); HIV (5x); HIV/AIDS (−); STI (1x)	Contracepti* (3x); FP (4x)	M&NH (4x)[a]; MH (17x); NH (−)	Abortion (1x)	–	–

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Table 1 (*continued*)

Policy documents and strategic plans	SRHR elements	SRHR core principles	SRHR components						
	SRHR, SRH, SRR, Reprod Rights (RR), Sexual Rights (SR)	Autonomy, Choice	Gender-based violence (GBV), Violence against women (VAW), Sexual violence (SV)	HIV/AIDS and other STI	Contraception/ contraceptive, Family planning/FP	Maternal & newborn health (M&NH), Maternal health (MH), Newborn health (NH)	Abortion, post-abortion	Infertility	Reproductive cancer, Cervical cancer
GFF Strategy 2021–2025: Protecting, promoting, and accelerating health gains for women, children and adolescents. October 2020. https://www.globalfinancingfacility.org/gff-strategy-2021-2025-protecting-promoting-and-accelerating-health-gains-women-children-and	SRHR (1x); SRH (3x); SRR (−); RR (−); SR (−)	–	GBV (2x); VAW (−); SV (−)	AIDS (1x); HIV (1x); HIV/AIDS (1x); STI (−)	Contracepti* (3x); FP (6x)	M&NH (17x)[a]; MH (1x); NH (−)	Abortion (2x)	–	–

[a] Note: GFF uses the broader term maternal, newborn, child and adolescent health.

Table 2
Global programmes by SRHR component, with organisations involved, programme objectives, external evaluations/reviews, and frequency counts of SRHR elements and core principles mentioned in these evaluations and reviews.

Programme name and period, website	Organisations involved	Programme objectives	External programme evaluations and reviews (including thematic evaluations) between 2012 and 2020	Frequency counts of SRHR elements and core principles in programme evaluations and reviews
Gender-based violence				
Joint Programme to Eliminate Female Genital Mutilation, 2018–2021 (phase III). http://www.unfpa.org/joint-programme-female-genital-mutilationcutting	UNFPA and UNICEF	"Prevention of harmful practices against adolescent girls and (young) women".	UNFPA/UNICEF (2019)[41]	SRH (3x); SRHR (1x) Autonomy (−); Choice (2x)
UNFPA support to the prevention of, response to and elimination of GBV and harmful practices, 2012–2017. https://www.unfpa.org/gender-based-violence	UNFPA	"Creating outcomes in terms of changes to political and legal norms, gender and social norms, institutional services, and in number of lives saved".	UNFPA (2018)[40]	SRH (55x); SRHR (1x) Autonomy (−); Choice (1x)
Spotlight initiative programme. Ending violence against women and girls, 2011–2030. https://www.spotlightinitiative.org/	UN Women	"Ending all forms of violence against women and girls by 2030, to empower, promote, and protect the rights of women and girls worldwide".	No external evaluation	–
UN Women's contributions to the Secretary-General's UNiTE to End Violence against Women campaign and the United Nations Trust Fund to End Violence Against Women (UN Trust Fund), 2008–2015. https://www.unwomen.org/en/what-we-do/ending-violence-against-women/	UN Women	"Preventing violence against women (VAW) and expanding access to related services".	UN Women (2013)[39]	SRH (−); SRHR (−) Autonomy (−); Choice (−)
UNFPA-UNICEF Joint Global Programme to End Child Marriage, since 2016 (ongoing). https://www.unfpa.org/unfpa-unicef-global-programme-end-child-marriage/	UNFPA and UNICEF	"To tackle child marriage in 12 of the most high-prevalence or high-burden countries".	UNFPA/UNICEF (2019)[38]	SRH (12x); SRHR (3x) Autonomy (−); Choice (13x)
Essential Services Package for Women and Girls Subject to Violence, One Stop Centre Model, since 2013 (ongoing). https://www.unwomen.org/en/digital-library/publications/2015/12/essential-services-package-for-women-and-girls-subject-to-violence/	UN Women, UNFPA, WHO (plus UNDP and UNODC)	"Providing greater access to a coordinated set of essential and quality multi-sectoral services for all women and girls who have experienced gender based violence".	Olson et al. (2020)[42]	SRH (−); SRHR (−) Autonomy (−); Choice (−)
GBV in the organisation, since 2018 (ongoing). https://www.unaids.org/sites/default/files/humanresources/EthicsSexualExploitation	UNAIDS	"To establish a safe working environment".	UNAIDS (2018)[43]	SRH (−); SRHR (−) Autonomy (1x); Choice (4x)
GBV in the organisation, since 2018 (ongoing). https://www.unicef.org/our-fight-against-sexual-exploitation-abuse-and-harassment	UNICEF	"To establish a safe working environment".	UNICEF (2018)[44]	SRH (−); SRHR (−) Autonomy (−); Choice (−)
HIV/AIDS and other STI				
UNFPA support to HIV/AIDS, since 1998 (ongoing). https://www.unfpa.org/hiv-aids	UNFPA	"To promote human rights and reduce inequalities, integrate HIV responses into sexual and reproductive health care, and prevent sexual transmission of HIV".	UNFPA (2020)[48]	SRH (23x); SRHR (14x) Autonomy (−); Choice (−)
PMTCT/Paediatric HIV Care and Treatment Programme, since 2006 (ongoing). https://data.unicef.org/topic/hivaids/paediatric-treatment-and-care/	UNICEF	"To eliminate HIV transmission from mother to child".	ITAD (2017)[49]	SRH (4x); SRHR (−) Autonomy (−); Choice (11x)
UNAIDS is a joint programme in itself, uniting the efforts of 11 UN organisations (co-sponsors) in the field of HIV/AIDS, since 1996 (ongoing). https://www.unaids.org/en	UNAIDS	"The Joint United Nations Programme on HIV and AIDS (UNAIDS) calls for countries to improve diagnosis of HIV, access to antiretroviral therapy (ART) and achievement of viral	Levi et al. (2016)[50] Marsh et al. (2019)[51]	SRH (−); SRHR (−) Autonomy (−); Choice (−) SRH (−); SRHR (−) Autonomy (−); Choice (−)

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Table 2 (*continued*)

Programme name and period, website	Organisations involved	Programme objectives	External programme evaluations and reviews (including thematic evaluations) between 2012 and 2020	Frequency counts of SRHR elements and core principles in programme evaluations and reviews
		suppression with the 90-90-90 targets".		
The HIV/AIDS Programme Strengthening the health sector for universal access to HIV prevention, treatment and care, since 2008 (ongoing). https://apps.who.int/iris/bitstream/handle/10665/43559/9789241594721_eng.pdf	WHO	"To strengthen the health-sector response to what continues to be one of the world's leading infectious killers".	No external evaluation	–
Leadership and participation, since 2012 (ongoing). https://www.unwomen.org/en/what-we-do/hiv-and-aids	UN Women	"To empower women and guarantee their rights so that they can protect themselves from infection, overcome stigma, and gain greater access to treatment, care and support. To help to amplify the voices of women living with HIV".	No external evaluation	–
Financial support to national HIV/AIDS programmes (ongoing). https://www.theglobalfund.org/en/	GFATM	"To support national HIV/AIDS programmes".	No external evaluation	SRH (23x); SRHR (14x) Autonomy (−); Choice (2x)
Contraception				
Global programme to enhance reproductive health commodity security (GPRHCS), renamed as 'UNFPA Supplies Partnership', since 1968 (ongoing). https://www.unfpa.org/unfpa-supplies-partnership	UNFPA	"To expand access to family planning for LMIC".	UNFPA (2018)[53]	SRH (45x); SRHR (−) Autonomy (2x); Choice (25x)
Global Financing Facility, launched in 2015 (ongoing). https://www.globalfinancingfacility.org/	GFF	"To offer grants to so far 36 countries for FP among other areas alongside routine World Bank lending for health".	Silverman et al. (2020)[54]	SRH (−); SRHR (−) Autonomy (−); Choice (−)
Maternal & newborn health				
UNFPA flagship programme: Maternal and Newborn Health Thematic Fund (MHTF), launched in 2008; 3rd phase 2018–2022. https://www.unfpa.org/maternal-and-newborn-health-thematic-fund	UNFPA	"To promote evidence-based interventions, policies and technical guidance; roll out and operationalize the six pillars of UNFPA's Global Midwifery Strategy (2018–2030)".	No external evaluation	–
H6 (previously H4) Joint Programme: Delivering health results for women, children and adolescents everywhere (2012–2019). H6 Joint Programme Report (2012–2019)- Delivering health results for women, children and adolescents everywhere (unfpa.org)	UNFPA, UNICEF, UN Women, UNAIDS, WHO (plus WB)	"To provide catalytic and strategic support to national health systems to address the root causes of poor maternal and child health outcomes in 10 countries, along with global-level activities".	CEPA (2020)[57]	SRH (6x); SRHR (2x) Autonomy (−); Choice (1x)
H4 Joint Programme: Delivering health results for women, children and adolescents everywhere (2011–2016). https://www.unfpa.org/admin-resource/evaluation-h4-joint-programme-canada-and-sweden-2011-2016	UNFPA, UNICEF, UN Women, UNAIDS, WHO (plus WB)	"To accelerate progress towards the achievement of Millennium Development Goals 4 and 5, and contribute to the implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)".	UNFPA (2017)[58]	SRH (11x); SRHR (1x) Autonomy (−); Choice (−)
GFF supports maternal, newborn, child adolescent programmes, since 2015 (ongoing). https://www.globalfinancingfacility.org/introduction	GFF	"To end preventable maternal, newborn, child, and adolescent deaths and to improve the health and quality of life of women, children, and adolescents".	No external evaluation	–
Every Newborn Action Plan (ENAP), launched jointly by WHO/UNICEF's maternal, newborn, child and adolescent health programme, since 2014 (ongoing). https://www.who.int/initiatives/every-newborn-action-plan	WHO and UNICEF	"To achieve coverage of care for all women and newborns through links with other global and national plans and measurement and accountability frameworks".	Kinney et al. (2015)[59]	SRH (−); SRHR (−) Autonomy (−); Choice (−)
Abortion				

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Table 2 (*continued*)

Programme name and period, website	Organisations involved	Programme objectives	External programme evaluations and reviews (including thematic evaluations) between 2012 and 2020	Frequency counts of SRHR elements and core principles in programme evaluations and reviews
Global support to safe abortion services, since 2012 (ongoing). https://www.who.int/health-topics/abortion#tab=tab_1	WHO	"To strengthening sexual and reproductive health policies and programmes to address unintended pregnancy and unsafe abortion".	Rashid et al. (2017)[60]	SRH (14x); SRHR (−); Reproductive rights (4x) Autonomy (−); Choice (−)
Infertility				
No global programmes	–	–	–	–
Reproductive cancers				
UN Joint Global Programme on Cervical Cancer Prevention and Control, 2016–2021. UN Joint Global Programme on Cervical Cancer Prevention and Control (who.int)	WHO, UNFPA, UNAIDS, UNICEF, UN Women (plus IAEA and IARC)	"To take new technologies to scale, reduce the cost of vaccines, and use innovative approaches to ensure women are accessing services".	No external evaluation	–

- the integrated SRHR concept and its constituent elements (sexual health, reproductive health, sexual rights, reproductive rights), as well as sexual and reproductive health;
- the two core principles of SRHR (personal autonomy and freedom of choice); and
- the seven SRHR components.

Based on this table and the qualitative text analysis, and taking into account the specific mandates of the respective global agencies, the extent to which they attempt to cover the various SRHR dimensions and adhere to the two core principles is assessed.

4.1.1. SRHR as an integrated concept versus its constituent elements

None of the seven global agencies had an overall, inclusive SRHR policy in place. WHO used to have a Sexual and Reproductive Health medium-term strategic plan (2010–2015) without 'rights' in its title. None of the seven global agencies mentioned 'sexual rights' in their policy documents, while four of them (UNFPA, WHO, UNICEF and UN Women) included 'reproductive rights'; almost half of their policy documents did so (nine times in twenty different documents). In 2015, following the adoption of and in line with the SDGs, WHO led the development of the 2016–2030 Global Health Strategy for Women, Children and Adolescents. This strategy mentioned the term SRHR just once and SRH nine times; neither reproductive rights nor sexual rights were mentioned. UNDP, UNICEF, UNFPA and UN Women developed a common chapter in their respective strategic plans (2018–2021), entitled "*Working together to* support *implementation of the 2030 Agenda*". SRHR as an integrated concept appeared only once in this common chapter. Instead, two of its constituent elements were used several times, but separately, without mentioning their interrelationship: Sexual and Reproductive Health (SRH ten times) and Reproductive Rights (RR, 11 times) – see Table 1. Before 2015, only WHO used the term reproductive rights as a stand-alone term (12 times in the 2010–2015 Strategic plan), while UNICEF, UNFPA, WHO, UN Women started using it after 2015.

4.1.2. Core principles

Table 1 further illustrates that the two SRHR core principles, autonomy and choice, were little used in the respective policies. The two funding agencies (GFATM and GFF) did not use these terms at all. The five UN agencies did use them, although sparingly.

4.1.3. SRHR focus of global agencies in relation to their respective mandates

UNFPA. As an implementation agency and former lead of the ICPD Programme of Action, UNFPA can be considered the UN's main SRHR agency. UNFPA focuses on reproductive health programmes, emphasizing family planning, access to modern contraceptives, and sexuality education for adolescents to avoid unintended pregnancies. Its overall strategy (2018–2021) fully recognized the importance of comprehensive sexuality education for young people: *"UNFPA's approach: Access to comprehensive sexuality education, supportive families and peers, safe schools and spaces for adolescents, and the development of skills and other assets set adolescents and youth on a positive trajectory to adulthood"*.

The ICPD Programme of Action built on the first major international agreement to tackle unsafe abortion [35]. ICPD recommended that quality abortion care, including contraception counselling and provision, "*be made available to all women, regardless of the legal grounds for abortion*" [36]. In one of its earlier strategies (the Strategy on Adolescents and Youth, 2012–2015), UNFPA recognized the risks of unsafe abortions, mentioning abortion five times and post-abortion once (Table 1). In its follow-up Strategic Plan (2018–2021) the terms abortion or post-abortion were absent altogether, while in its Business Plan on Maternal and Newborn Health Thematic Fund (2018), abortion was mentioned 43 times and post-abortion 18 times (Table 1). In UNFPA's strategy (2019) Rights and Choices for all adolescents and youth, (unsafe) abortion was mentioned once: "*We act to prevent unsafe abortion and its consequences*".

On its website, UNFPA explicitly states that the organisation *"… does not promote abortion. Rather, it accords the highest priority to*

voluntary family planning to prevent unintended pregnancies in order to eliminate recourse to abortion. UNFPA does not promote changes to the legal status of abortion, which are decision-making processes that are the sovereign preserve of countries" [37]. This contrasts with the ICPD recommendation that women should have access to safe abortion, regardless of the legal grounds for abortion. Although treating unsafe abortions has officially been on the global public health agenda since the Programme of Action of the 1994 ICPD, and all UN member states committed themselves to improving access to and the quality of post-abortion care [38], UNFPA seems not to embrace this.

WHO. As a specialised technical agency, WHO is mandated, among others, to establish, monitor and enforce international health norms and standards. WHO provides leadership in working towards worldwide universal health coverage (UHC) by 2030 [39] and therefore the organisation has an important role to play in integrating SRHR into the UHC agenda. A joint statement to this effect, at the initiative of the Netherlands' Minister of Foreign Trade and Development Cooperation at the UN General Assembly High-level Meeting on UHC in September 2019, emphasized the importance of SRHR as a cornerstone of UHC. Fifty-eight signatory countries committed to fully implementing the UHC political declaration in their own countries as well as abroad [40]. Table 1 shows that, after 2015, WHO used SRHR parsimoniously as an integrated concept in its policies. Of its four relevant policy document that came out since then (listed in the same table), two did not mention SRHR, with each of the other two mentioning it just once. Whereas the earlier SRH Medium-term strategic plan (2011–2015; 98 pages in total) used the term SRHR four times, the global strategy 'Every woman, every child' (108 pages in total) did so only once. As an interagency special programme, the Human Reproduction Programme (HRP), based at WHO headquarters, was not included in the analysis since it deals with research, development and research training. WHO is also leading in the development of normative standards and guidelines, along with the provision of technical assistance to member countries (for instance on STI, contraception, maternal and newborn health); this is not necessarily covered by the policy documents, strategic plans and global programmes included in this study.

UNAIDS. As a joint programme of six UN agencies on HIV/AIDS (UNICEF, UNDP, UNFPA, UNESCO, WHO and the World Bank), UNAIDS provides leadership in the global response to the HIV epidemic and emphasizes the 90-90-90 treatment targets. The integrated concept of SRHR is little used in UNAIDS policy documents. Two of the five policy documents reviewed mentioned SRHR: the 2016–2021 Strategy (eight times) and the 2020 Policy brief (four times; Table 1). To further verify whether UNAIDS integrates SRHR in its mission, the Director's speeches held during the biannual Programme Coordinating Board meetings in the period from 2013 to 2020 were reviewed. The Director mentioned SRHR once or twice in some speeches. UNAIDS did not emphasize the interconnectedness of SRHR and HIV, with no explicit mentioning of sexual rights, (women's) lack of autonomy or limited freedom of choice as factors that co-determine HIV transmission.

UNICEF. As a social welfare organisation, UNICEF's mandate is the survival, protection and development of children worldwide through the provision of humanitarian and development assistance. It is guided by the Convention on the Rights of the Child. Three of the five UNICEF policies reviewed mentioned sexual health and reproductive health but did not refer to SRHR as an integrated concept. The other two policy documents each mentioned SRHR once: the 'Common chapter' and the Education strategy 2019–2030, which states: *"Examples of collaboration with other sectors include, but are not limited to, the following: Health: (1) health services ….; (2) health education and promotion (including healthy eating, comprehensive sexuality education, sexual and reproductive health and rights, menstrual hygiene management, and mental health); and (3) healthy schools …"*. UNICEF's Education strategy pursues collaboration with the health sector, but there was no such confirmation in UNICEF's Health strategy, which mentioned neither SRHR nor sexuality education. Indicative of UNICEF's hesitance to fully embrace adolescent SRHR is the following quote in the agency's Health strategy: *"Adolescents, ages 10–18. UNICEF's focus for this age group is similar to its focus for children ages 5–9, given that the health challenges faced by the two age groups are similar. What is different for adolescents is the need to also address sexually transmitted diseases (especially HIV) and the health risks associated with adolescent pregnancy."* Neither the education strategy nor the health strategy provided any other reasons to promote sexuality education for adolescents.

UN Women. Established to promote gender equality and women's empowerment, and to accelerate progress on meeting the needs of women and girls worldwide, UN Women is mandated to hold the UN system accountable, and interrogate countries that ratified the Convention on the Elimination of all Forms of Discrimination Against Women on their commitments to gender equality, and to monitor progress in this regard. SRHR not being part of UN Women's mandate, four of its five policy documents reviewed do not mention SRHR. Meanwhile, there are several mentions of Gender-based violence, Violence against women, and Sexual violence, which fall under the SRHR framework's first component. Only the 'Common chapter' mentions SRHR once. UN Women's Strategic Plan 2018–2021, which outlined its strategy to support efforts to achieve gender equality and empower women and girls, did not refer to SRHR either. A frequency count of the term 'autonomy' in the five UN Women's policy documents showed three mentions. UN Women's 2015 Policy brief 'Making national social protection floors work for women' stated that: *"Women face particular barriers to income security and often see their well-being and autonomy limited as a result"*, while the Strategic Plan 2018–2021 stated that *"Women have income security, decent work and economic autonomy"*. In their pursuit of women's autonomy, UN Women's policies appeared to solely refer to the economic dimension.

GFATM. The Global Fund positions itself as a partnership and a movement. Its mandate is to accelerate progress against three infectious diseases (HIV, tuberculosis, malaria) and improve global health more in general. While an earlier global strategy (2012–2016) did not mention SRHR or one of its constituent elements, the follow-up strategy (2017–2022) mentioned it once: *"Scale up programs to* support *women and girls, including programs to advance sexual and reproductive health and rights"*. To further analyse to what extent GFATM integrates SRHR in its strategy, the latest replenishment investment cases were reviewed. These are three-yearly written requests of GFATM to its donors to advocate for a renewal of their funding commitments, supported by projections of the results that GFATM could achieve for its three target diseases with a prioritized set of investments. None of the replenishment investment cases reviewed (the 4th, 5th and 6th, covering 2014–2016, 2017–2019 and 2020–2022, respectively) referred to SRHR

[40–42].

GFF. GFF aims at scaling up access to affordable, quality care for women, children and adolescents. While GFF's first strategy, referred to as Concept note (2015–2020), did not mention SRHR, the latest strategy (2021–2025) mentions it once: *"The GFF is designed to help governments ramp up provision of a broad scope of quality, affordable primary health care services critical for improving the health and nutrition of women, children and adolescents—including, but not limited to, family planning services, antenatal care, obstetric care, services to prevent stillbirth, neonatal care, postnatal care, child immunization, sexual and reproductive health and rights (SRHR) services and other child and adolescent health and nutrition interventions—all of which require an integrated approach to resolve systemic barriers to effective service delivery*". It is not stated that most of the cited services could be considered integral parts of SRHR.

4.1.4. SRHR components across the global agencies' policies

All seven agencies mentioned three of the seven components of SRHR in their policies: gender-based violence, HIV (although 'other STI' receive much less attention) and maternal health (with UNAIDS, UN Women and GFATM not mentioning 'new-born health'). Maternal and new-born health is addressed in almost all policy documents or strategic plans of UNFPA, WHO, UNICEF and GFF. Whereas UNFPA, WHO, UNAIDS and GFF address contraception and/or family planning in almost all their policy or strategic documents, UNICEF and UN Women hardly did so, and GFATM not at all. UNFPA, WHO and GFF mentioned (safe) abortion in most of their policies, while there was no mention of (safe) abortion in the policies of UNAIDS, UNICEF, UN Women and GFATM. WHO was the only agency among the seven that had (safe) abortion as one its focus and openly advocated for it, for example by issuing guidelines for health workers how to safely perform an abortion areas [43]. Infertility was mentioned frequently by WHO (in its Medium-term SRH strategic plan 2010-15; less so in the STI Strategy 2016-21), once each by UNFPA and UNAIDS, and not at all by the other agencies. Reproductive cancers, especially cervical cancer, were addressed by WHO (in four of its five policy documents), as well as by UNFPA and UNAIDS (in one of the policy documents of the two organisations).

4.2. Programme analysis

Of the 23 identified global SRHR-related programmes undertaken by the seven global agencies, seven were jointly implemented by two or more agencies. Four of them had been completed by mid-2020, the others were on-going. None of the agencies had an SRHR programme that covered all seven components. The 23 programmes are listed in Table 2, grouped by SRHR component, with their respective external evaluations and reviews, of which 17 were identified in total.

Seven global programme evaluations/reviews addressed GBV, followed by HIV (four), MNH (three), Contraception (two), Abortion (one). The word counts and text analyses of published SRHR programme evaluations and reviews revealed that none of these publications explicitly referred to any of the two SRHR core principles of interest in the present analysis, with few of them mentioning 'choice' in relation to contraceptive methods, and hardly any using the term (personal/individual) 'autonomy' (Table 2). The findings per SRHR component are presented below.

4.2.1. Gender-based violence

All five UN agencies implemented GBV programmes, some of which used the term Violence against women (VAW) or Sexual violence (SV), with a total of eight programmes, for which seven study reports were identified: six evaluations and one journal article. Seven of the programmes addressed prevention, and one focused on care for GBV survivors. They contributed significantly to norm setting: "*UNICEF and UNFPA have been successful in advocacy for eradication of child marriage, bringing substantial contributions to normative frameworks at all levels"* [44]. Two evaluations found that the GBV programmes had increased awareness on GBV issues, but a measurable reduction in harmful practices, which is of course more difficult to detect, was found to be generally missing [45,46]. The UNFPA-UNICEF Joint Global Programme to End Child Marriage received only 40 % of the expected, planned funding, which partly explained the limited scale-up and achievements of the interventions [44]. Several evaluations found an insufficient shared understanding of the complementarity of the different UN agencies' work on GBV and how to implement a joint GBV programme at the country level [45,46]. One evaluation found data gaps in validating how a tailored set of interventions aimed at reducing GBV had actually led to changes in collective and individual FGM behaviours, and in changes in FGM prevalence [47]. Although several evaluations emphasized that human rights are central to the GBV programmes – for example, *"Human rights are at the core of its operations and child marriage is largely understood as a human rights violation among stakeholders at all levels"* [4] – the term SRHR was only mentioned in three of the seven studies, all evaluations of UNFPA (joint) programmes (References 44–46 in Table 2). The other four studies on GBV did not mention SRHR.

The GBV programme that comprises care for survivors of sexual assault, referred to as the One Stop Center (OSC) model, was established following a recommendation in in the 2012 UN Women's handbook to support National Action Plans on Violence against Women. The OSC model was applied in 24 countries in which UNFPA, UNICEF and/or UN Women worked together with national governments. A systematic review in 2020 found no evidence of any scale-up of the OSC model [48]. The lack of scaled-up GBV programmes was also reported by the GLCo [4].

In 2018, UNICEF took the initiative to integrate prevention of GBV in the organisation and all its programmes [49]. UNAIDS decided to do the same, after it had received reports and claims of sexual assault in the workplace [50]. Both UN organisations commissioned teams of consultants to study GBV within their own organisations (references [51]–[52] in Table 2). In 2019, UN Women issued a guideline, under the title "*What will it take*?", to facilitate organisational changes similar to those started by UNICEF and UNAIDS: *"The culture of an organisation is reflected in its personnel – who is hired and where they are placed in the organization; management and leadership are especially relevant"* [53]. The guideline aimed to respond to the need, often unexpressed, to transform

internal cultures of global agencies.

4.2.2. HIV and other STI

There is no global programme on sexually transmitted infections. With UNAIDS designated to coordinate the response to HIV, the other four UN agencies included in this analysis (WHO, UNICEF, UNFPA and UN Women) are among the group of UNAIDS cosponsors. At the same time they also undertake global HIV programmes themselves, within their own respective mandates. Two of them, UNICEF and UNFPA, had their HIV programmes evaluated. The evaluation report of UNFPA's HIV programme mentioned SRHR fourteen times [54]; UNICEF's HIV programme evaluation report concluded that support to the national level scale-up of HIV prevention, care and treatment services for children had been successful, but did not refer to SRHR a single time [55].

UNFPA's approach to increase access by the most vulnerable and key populations to quality HIV services was evaluated less favourably than its support to linking and integrating SRHR, HIV and SGBV services. "*UNFPA business model that does not foresee service delivery as a mode of engagement in many countries. This constrains the capacity of country offices to address the ability of the most vulnerable and key populations to access quality services in HIV prevention, testing and treatment free of discrimination*" [54]. Two systematic reviews focused on UNAIDS' global 90-90-90 treatment target. They indicated that this ambitious target had not yet been met by any individual country, despite good and steady progress in access to treatment [56,57].

Although there was no formal evaluation of GFTAM's global HIV programme, the response to HIV is reported to have scaled up considerably, with 27.5 million people accessing antiretroviral therapy in 2020 compared with 21 million people four years earlier (in 2016) [4]. In their Viewpoint article in The Lancet in 2019, Friebel et al. called for more modesty in claiming impact [58]. They observed that HIV funding agencies, including GFATM itself, and implementing organisations tend not to publicly acknowledge uncertainty in the evidence base underpinning the estimates of their own impact. Hence there would be need for a more "*robust, frank, and respectful public dialogue about the strength of the evidence*".

4.2.3. Contraception

Two of the seven agencies, UNFPA and GFF, had programmes to support contraceptives supply systems, both of which were externally reviewed. The mid-term evaluation of the UNFPA Supplies Programme found that activities to shape global markets and reduce unit costs had had "… *limited success in broadening sustainable sources of financing for reproductive health commodity security and family planning …",* but remained *"… the dominant source of commodities used by the public sector in almost all programme countries"* [59]. So far, family planning financing and delivery is largely a vertical donor-dependent activity, with little supply-chain management by recipient countries themselves. This was found to complicate the integration of family planning into national universal health coverage (UHC) schemes and service benefit packages [59]. In the case of GFF, both the approach to articulating priority interventions and the degree of prioritization vary widely across countries. Overall, evidence on the extent of financing of family planning through GFF operations remains limited, and supply chain bottlenecks have contributed significantly to persistent high stockout rates for contraceptives in LMIC [60]. Another study confirmed that global family planning programmes to address the widespread unmet need for contraceptives in LMIC had not yet succeeded in ensuring reliable contraceptive supply chains at the country level [61]. The current global reproductive health commodities supply chain system is reported to be highly complex. *"There is no consensus on which interventions contribute to increased availability of Reproductive Health Commodities. General descriptions of the broad range of existing projects and (pilot) interventions are available, but the body of evidence about the results and impact of these projects and interventions remains limited. Without in-depth understanding of why an intervention works or not in a certain context, its replication or scaling may not be successful. Scaling up of successful (small) pilot interventions is stated as a major undertaking requiring considerable investments"* [62].

4.2.4. Maternal & newborn health

Six organisations (all except GFATM) support global programmes in the massive continuum of maternal & newborn health care, for a total of five programmes, of which two programmes that had ended and were evaluated (the H6 Joint Programme, involving five UN agencies and the World Bank; and its predecessor the H4 Joint Programme) [63,64]. The two evaluations reported positive outcomes, such as reductions in home deliveries, improved antenatal care attendance, and increased access to emergency obstetric and newborn care. The integration of HIV and AIDS programming into health services was found effective, but the integration of family planning into reproductive maternal newborn child adolescent health services had failed. Overall the needs of youth and adolescents were insufficiently addressed. A journal article reviewing the UNICEF/WHO Every Newborn Action Plan argued that implementation at country level was well-supported, with some of the highest burden countries having established newborn health action plans and scaling up evidence-based interventions [65].

4.2.5. Abortion

An evaluation of WHO's strategic approach to strengthen SRH policies and programmes found that 15 countries that had requested WHO's technical support in addressing unintended pregnancy and unsafe abortion had succeeded to systematically pay attention to these topics, with some countries focussing on reforming policies to improve access to SRH services and others on improving provider-level capacity to enhance SRH service quality and improving community-level SRH education [66]. Globally, the capacity of primary-level and referral-level health facilities to provide basic and comprehensive post-abortion care, respectively, remains low [67].

4.2.6. Infertility

None of the reviewed seven global agencies have a global programme on human infertility. This in spite of the fact that … *"Female*

infertility, including tubal factor infertility, is a major public health concern worldwide. Most cases of tubal factor infertility are attributable to untreated sexually transmitted diseases that ascend along the reproductive tract and are capable of causing tubal inflammation, damage, and scarring" [68]. Within the HRP, WHO does coordinate research and report on infertility but this is not covered in this analysis of policies and global programmes.

4.2.7. Reproductive cancers

There was just one programme: the UN Joint Global Programme on Cervical Cancer and Control, 2016–2021, which involved all five reviewed UN organisations. It had not been evaluated yet at the time of this study.

5. Discussion

The seven global agencies that formed the study object did not explicitly acknowledge autonomy or freedom of choice as fundamental to SRHR. This corroborates findings from a 2019 post-hoc analysis of two family planning initiatives - started after the 2012 London Summit on Family Planning - which found that the notion of population control still persisted, alongside much cited human rights and women's empowerment approaches, without explicitly addressing autonomy and choice in accessing services [69]. Another study, from a sub-Saharan African country whose name was not disclosed, reported how women experience biased counselling, limited offer of mixed contraceptive methods, scare tactics, provision of incomplete or false medical information, refusal to remove provider-dependent methods, and provision of long-acting methods without their consent [70]. When offering family planning services and contraceptive methods, many programmes still appeared to employ coercive practices rather than acknowledging women's autonomy and clients' freedom choice [71]. O'Brien and Rich introduced the term 'obstetric violence', referring to harm inflicted during or in relation to pregnancy, child bearing and the post-partum period and put this into a historical perspective [72]. They point out that such violence can be both interpersonal and structural, arising from healthcare providers' actions as well as from wider political and socio-economic arrangements that disproportionately harm marginalized populations. It is an unevenly distributed but global phenomenon, rooted in past oppressions and social inequities. Our findings support the authors' call for greater awareness among health professionals and respectful reproductive care that supports patient dignity and autonomy. Here is a more prominent role for international agencies to play.

A recent systematic review of supranational reports and guidelines on the prevention of sexual violence, not limited to the health domain, published by four UN agencies considered the natural and legitimate lead organisations to provide professional guidelines for the prevention of sexual violence (WHO, UN Women, UNESCO and UNICEF) [73]. About three quarters of all publications (50 in total), concerned primary prevention of sexual violence; a minority concerned tertiary prevention (37 %), but this type of prevention was poorly developed and polarized between survivors and perpetrators; some publications covered both primary and tertiary prevention, and none addressed secondary prevention, despite the proven effectiveness of approaches such as helplines for people sexually attracted to children. The publications focused mostly on violence (85 %), typically referred to as interpersonal behaviours without further specification, with few focussing on sexual health (13 %) or education guidelines (2 %). The review does not shed light on the extent to which existing guidelines are integrated into ongoing SRHR programme, but this would be worth exploring.

Most SRHR programmes not only focus on prevention, they are primarily centred on adverse physical conditions, with little attention to mental health in relation to SRHR, including the promotion of mutually respectful relationships, sexual health and wellbeing, or sexual pleasure. Of late though, there has been a noticeable change, with for example the launch of a Global Acceleration Plan for Gender Equality, in July 2021, by 'Leaders and Commitment Makers' from governments, the private sector, civil society, youth, philanthropy and international organisations [74]; the 77th session of the United Nations General Assembly, in 2022–23, which paid attention to SRHR [75]; the World Health Assembly approval, in May 2023, of new global health sector strategies on HIV, hepatitis viral and sexually transmitted infections (2022–2030), despite multiple abstentions from the final vote and strenuous objections by some conservative governments to some of the language used (including the term 'sexual health') and the inclusion of certain target populations for HIV treatment [76]; the second UN High-Level Meeting on Universal Health Coverage, in Sept 2023, with the adoption of a Political declaration that calls for universal access to SRHR, condemning sexual and gender-based violence, and harassment in the workplace [77]; a joint statement by HRP, WHO, UNDP, UNFPA and the World Bank, at the World Health Summit in October 2023, to advance universal health coverage of SRHR, including comprehensive SRHR education [78]; and the announcement by WHO in December 2023 of the development of a guideline on the health of trans and gender diverse people [79]. Also worth mentioning is the remarkable work of the Human Reproduction Programme HRP with a richly referenced WHO website on sexual health [80]. While all this demonstrates good progress overall in several areas of sexual and reproductive health, it has been geographically uneven and in the context of growing conservatism important challenges remain, in particular for adolescent mental health [81].

Another recent commentary paper that focuses on 'the second R' in SRHR points out that data on norms and values related to SRHR and gender are limited [82]. It questions whether ODA for SRHR sufficiently considers the normative challenges that undermine equity, inclusiveness, and individual agency and autonomy, and the opportunities to overcome these challenges. Based on their analysis of all ODA for SRHR from the Swedish International Development Cooperation Agency (Sida) between 2010 and 2018, which, like the present study, was guided by GLCo's definition of SRHR, the authors pleaded for a more explicit inclusion of SRHR norms and values in ODA strategies to set priorities and guide project logic and evaluation processes. Another compelling editorial in BMJ Global Health calls for SRHR to focus not merely on tangible health outcomes, but, more significantly, also on reproductive and sexual agency, and for policies and interventions to more explicitly posit bodily autonomy as their objective. SRHR research and programmes would need to pay much fuller attention to gender norms and identities, sexuality and sexual health [83].

Besides the core principles of SRHR sporadically being addressed by global agencies in the documents reviewed, there was some heterogeneity in SRHR components on which global agencies could have pronounced themselves more explicitly, in line with their respective mandates and strengths. UNFPA could be more explicit about abortion, UNICEF about sexuality education not solely meant to prevent teenage pregnancies, WHO on standard setting for SRHR service packages as part of the UHC agenda, UNAIDS on the inclusion of 'other STI's' in HIV control, and UN Women on explicitly connecting bodily autonomy with economic autonomy. The two international funding agencies (GFATM, GFF) fell far short of paying due attention to the SRHR core principles. A possible joint global STI programme, which has been lacking, might piggyback on the successes of the global HIV programme. In June 2020, WHO convened a first informal think-tank meeting under the title "Accelerating the global sexually transmitted infections response", which also concluded that a global STI programme would not have to start from scratch, and "*a big advantage is that these infections are treatable and some are curable*" [84]. As STI's might lead to infertility, another component of SRHR, it shows the need for more intensive collaboration between the global institutions, a joint understanding and division of work. A more prominent involvement might be considered for the private sector, which so far has a rather limited role in reproductive health supply chains despite their successes in enhancing access to antiretroviral medication [61,62].

Until recently, the integrated concept of SRHR did not occupy a prominent place on the global UHC policy agenda, in spite of earlier calls to do so. The framework that WHO and World Bank developed to track progress in UHC comprises 16 essential services, divided into four categories, one of which is 'Reproductive, maternal, newborn and child health', with four services: family planning, antenatal and delivery care, child immunization and health-seeking behaviour for pneumonia. Antiretroviral treatment for people with HIV (in the category of Infectious diseases) and cervical cancer screening (in the Non-communicable diseases category) are two further essential services that are being monitored globally [85], but this is not a strong sign of full SRHR endorsement. Global health is about poverty and power relations and that makes it political [86]. Obviously, all global agencies have their own corporate values, ideologies and priorities, whereby their intervention logics and the trade-offs they make may be partially implicit or hidden [87]. In certain environments it may require courage to openly address the sexual or reproductive rights of women or of certain minorities [88], as values diverge among countries and constituencies, with various sensitivities. This calls for customised approaches that take local political and cultural contexts into account. At the global level, however, SRHR needs to be embraced holistically, in all its dimensions; and global agencies that claim to be working towards the advancement of the position of women and girls would need to include the core principles of SRHR more explicitly into their corporate policies and global programmes, even if they do not address all components. In case of any reservation, global agencies would need to clarify openly why certain dimensions of SRHR are not or only partially supported. The discourse in development policy about economic empowerment of women risks not to translate into goals being met as long as women's sexual and reproductive health and rights are not acknowledged and respected [89,90].

While all five UN agencies reviewed highly value gender equality and treat it as a cross-cutting theme [91], the gender dimension of SRHR was poorly acknowledged in their policy documents and global strategies, precisely because (women's) autonomy and freedom of choice received so little attention [92]. Ignoring the core principles of SRHR undermines gender equality aspirations and precludes the achievement of SRHR targets. Silencing individual agency, and ignoring personal autonomy and freedom of choice cannot be justified.

A topic for further study would be to identify the efforts that donor countries make, in particular those that are part of the Countdown2030 Europe consortium [28,29], individually or collectively, to convince recipient global agencies of the need for a holistic SRHR approach. Do these donors hold the global agencies accountable – bilaterally or jointly – for their SRHR performance, in particular their active endorsement of SRHR core principles? Donors tend to prioritise HIV programmes, which received 70 % of total SRHR donor funding in 2017 [25], while there was ample evidence that the integration or combination of HIV and SRHR had not been very successful [93]. The forces behind this anomaly deserve further scrutiny. Another topic for further study could be an in-depth exploration of how individual SRHR and gender specialists – both officers from within and outside of global agencies – as well as members of community groups, to unveil, through interviews and focus group discussions, what they perceive as enablers of and barriers to a more holistic SRHR approach and true endorsement of autonomy and freedom of choice; and how these principles could be incorporated into formal policies and global programmes, and implemented in practice. The role of political and sociocultural determinants of the identified enablers and barriers would deserve special attention, so as to develop suitable approaches that not only fit but also challenge the local context.

None of the global programmes explicitly tried to break through structural discrimination and harmful gender norms that inhibit SRHR. In some societies traditional values and norms may restrict women's autonomy and freedom of choice, and these may well be replicated and reinforced by health workers trained in western healthcare delivery models. This is something global SRHR programmes would need to acknowledge. International agencies and organisations could reflect more on ways to positively influence women's agency and enhance their capacity for bodily autonomy. Failure to acknowledge and actively promote women's individual autonomy and freedom of choice would stand in the way of further global progress in SRHR. There is scope for implementation research to co-design frameworks to redress power imbalances and inequities and to explore the potential of stakeholder involvement in policy processes and accountability strategies to realise SRHR ambitions [94].

One of the challenges is the diversity of constructs of individual autonomy, and how to make them measurable. Bhan et al. have pointed out that the lag in prioritising women's agency in family planning and contraceptive targets may be due, at least in part, to a lack of consensus in the meaning and measurement of women's agency [95]. One may argue that the same holds for women's agency and freedom of choice to access services in SRHR components other than contraception. Echoing Bhan et al., it can be contended that, along with bridging the gap between researchers and programme implementors, and resolving disciplinary tensions between gender and public health specialists, it continues to be important "to emphasize gender and rights frameworks within public health programmes so as to value women's satisfaction, dissatisfaction and even ambivalence with the choices available to them". Generally

speaking, women's agency, autonomy and freedom of choice would need to be conceptualised in all SRHR programmes in a way that is "palatable, accessible, appropriate for the context and easy to use for (programme) implementers".

This study has shown that global agencies have a history of tending to shy away from making linkages between the different components of SRHR, while in fact there is a great potential for synergy, especially in terms of conditions that need to be fulfilled: greater individual autonomy and freedom of choice in accessing services may serve as catalysts for all components. There is a need for global agencies to better underpin the rationale of SRHR and for stronger encouragement to consider more fundamentally the principles that form the core of SRHR and operationalize them in their global programmes. This would mutually reinforce the various SRHR components and shape the conditions for further progress of women's health globally.

Study strength and limitations

This study used a novel approach in that a conceptual framework, adapted from the one used by the GLCo for SRHR, was applied in three dimensions of SRHR (elements, components, core principles) to systematically analyse *post hoc* the corporate policies and programmes of the main global agencies that are active in SRHR. This resulted in a theme-wise comparative analysis and identification of relative strengths and shortcomings which may form a starting point to fill an evidence gap that has so far not been addressed by global SRHR champions and scholars. There is scope to conduct case studies, whereby single agencies are subjected to a more thorough analysis of policy documents in terms of holistic coverage of SRHR, perhaps complemented by expert interviews, to better understand the rationale for the use and operationalization of terminology around SRHR, as well as the context and manoeuvring space for agencies to design and implement SRHR programmes.

The literature search was conducted in August 2020, five months after WHO declared COVID-19 a pandemic (on March 11th, 2020), implying that none of the global agencies' policy documents, strategic plans and SRHR programmes could realistically have mentioned anything about COVID-19. A scoping review of the impact of the COVID-19 pandemic on access to and utilisation of sexual and reproductive health services, which included 83 studies, unsurprisingly pointed to negative impacts, especially among populations who were already marginalized [96]. The commentary paper by Sundewall et al. also argued that the gendered impact of the pandemic and associated mitigation measures have exposed and deepened existing SRHR-related inequalities [82].

The main limitation of this study is that it did not investigate the full scope of technical support, including SRHR guidelines, provided by global agencies to national or subnational SRHR programmes, nor the research activities that some agencies undertake outside global programmes. An example of the former is the International technical guidance on sexuality education, jointly published in 2018 by UNESCO, UNAIDS, UNFPA, UNICEF, UN Women and WHO [97]. An example of research activities, also mentioned earlier, is the interagency Human Reproduction Programme. There may have been successful but less well documented projects or small-scale initiatives to promote people's autonomy and freedom of choice that were not part of a global programme. Another limitation is that the quality of the evidence of the identified programme evaluations and reviews was not assessed.

6. Conclusion

Until 2020, two essential aspects of SRHR had not become part of mainstream thinking within global agencies, nor in circles of evaluators of global SRHR policies and programmes. By failing to explicitly acknowledge women's individual autonomy and freedom of choice as core principles of SRHR in their corporate policies and link these to their respective mandates and priorities, the seven agencies included in this review missed the opportunity to support activities that could enhance the emancipatory empowerment of women and girls to improve their sexual and reproductive wellbeing. This has contrasted with the advocacy narratives on human rights, gender equality and women's empowerment. A more critical reflection in programme evaluations and reviews on what constitutes the core of SRHR, and on the importance of linking women's autonomy and freedom of choice to programme activities would go a long way in refocusing global agencies' support for SRHR.

Global agencies could do more in their programmes to break through structural discrimination and harmful gender norms that inhibit SRHR. Traditional values and norms that restrict women's autonomy and freedom of choice should be challenged, where appropriate, also in health professional training programmes. Frameworks, co-designed through implementation research, could help redress power imbalances and inequities, while at the same time exploring the potential of stakeholder involvement in policy processes and accountability strategies to realise SRHR ambitions.

Ethics declarations

- Review and/or approval by an ethics committee was not needed for this study because all reviewed sources and publications are in the public domain.
- Informed consent was not required for this study because it neither involved any personal interviews nor any confidential sources.

Consent for publication

Not applicable.

Availability of data and materials

All data generated and analysed during this study are included in the article (in the tables and the references); the literature search string is included in Additional file 1. There are no other data associated with the study, hence there is no publicly available repository.

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CRediT authorship contribution statement

Anny J.T.P. Peters: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Conceptualization. **Leon Bijlmakers:** Writing – review & editing, Writing – original draft, Methodology, Investigation, Conceptualization.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

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