






Setting up a research agenda for financing sexual and reproductive health services toward achieving universal health coverage in South Asia

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Introduction

2019 marked the twenty-fifth anniversary of the International Conference on Population and Development Programme of Action, where 179 countries committed to advance sexual and reproductive health (SRH).¹ 2019 also marked the political declaration of the high-level meeting on universal health coverage (UHC).² These two events in tandem provided the momentum for achieving sexual and reproductive health and rights (SRHR) through UHC. They built on the 2018 Guttman-Lancet Commission report that provided a new and comprehensive definition of SRHR and detailed the health services required to achieve them.³ Furthermore, the Commission argued that investments in these essential SRH services would yield returns in achieving the Sustainable Development Goals, especially universal access (goals 3.7 and 5.6) and universal coverage (goal 3.8) in health. With consensus on these policy commitments, many countries have begun to integrate SRHR services in their country's UHC reforms. These focus on equity, access to quality services, coverage, and financial protection.¹

Countries adopt multiple sources of financing toward achieving UHC. These include, but are

not limited to, health services that are publicly financed and/or provisioned; publicly financed/operated health insurance programmes, usually for low-income and marginalised groups; publicly financed insurance schemes for government employees; publicly and privately financed workers' insurance schemes; health insurance/medical reimbursement through an employer; community health insurance programmes; and privately purchased health insurance. This commentary focuses on the first two: government health services and publicly financed/operated health insurance programmes.

Typically, services other than family planning (FP), maternal and child health (MCH), and HIV are not part of the health benefit packages in many countries.⁴ The Guttman-Lancet Commission³ recommended the expansion of SRHR to include comprehensive sexuality education; counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods; antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care; safe abortion services and treatment of complications of unsafe abortions; prevention and treatment of HIV and other sexually transmitted infections; prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence; prevention, detection, and management of reproductive cancers, especially cervical cancer; information,

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

Supplemental data for this article can be accessed at <https://doi.org/10.1080/26410397.2022.2040775>

counselling, and services for sub-fertility and infertility; information, counselling, and services for sexual health and wellbeing.³

In this commentary, we set forth an agenda identifying the scope of research to demonstrate the effectiveness of policies addressing SRHR within UHC. We documented the SRHR services that are covered or not covered, as per the Gutmacher-Lancet Commission's recommendation, under the current programmes aiming toward achieving UHC in Bangladesh, India, Nepal, and Pakistan. We described policy directions taken up by each country to address SRHR and posed illustrative research questions to assess the gaps in policy intent and implementation. By doing so, we aim to initiate dialogues with policymakers, programme managers, the SRHR community, and the research community on the scope of measurement, evaluation, and learning that can help bridge evidence gaps.

UHC schemes covering SRHR in selected South Asian countries

Our review of UHC programmes in Bangladesh, India, Nepal, and Pakistan shows that limited SRH services are included and largely provided by the public sector, with some differences in the ministry or administrative body responsible for oversight. In addition to achieving UHC goals, these programmes also focus on improving the quality of services. However, a sizable proportion of the population in these countries fails to access even these free or covered services, leading to catastrophic out-of-pocket (OOP) expenditures.

Primary health care is offered universally to all citizens by the public sector in these four countries, as a step toward achieving UHC. However, the provision of publicly financed/operated health insurance covering secondary and tertiary health care varies in each country. In India, the publicly financed health insurance programme involving the public and private health sectors covers poor and vulnerable families across the country.⁵ The Government of Pakistan's health insurance programme that engages public and private health sectors is targeted toward people living below the poverty line,⁶ although expansion to cover all citizens is under way. In Nepal, the government-run voluntary health insurance programme engages the public and private health sectors. All citizens are eligible to join the programme, if they are willing to pay the premium,

and the programme charges a subsidised premium for families living below the poverty line.⁷ In Bangladesh, a government-run health insurance programme is being piloted with donor support in a smaller geography.^{8,9}

Each country's publicly financed insurance programme offers a similar set of selected SRH services with slight variations and covers different levels of care. India's *Ayushman Bharat* programme has two inter-related components, Health and Wellness Centres (HWC) and *Pradhan Mantri Jan Arogya Yojana* (PM-JAY).¹⁰ The private providers can provide healthcare services along with other public sector personnel at the HWCs, and under PM-JAY, public sector hospitals and empanelled private hospitals provide secondary and tertiary care. The services provided at HWCs include antenatal, natal, and postnatal care services; counselling and provision of contraceptive methods; and screening for HIV and other sexually transmitted infections.¹¹ Services such as management of delivery complications, clinical FP services, surgical abortion, and treatment for HIV/AIDS are covered under the insurance mechanism and provided at the secondary and tertiary level, or covered by other government-run health programmes such as the National Health Mission and the National AIDS Control Program.^{12,13}

In Pakistan, all public healthcare facilities are mandated to provide FP counselling and services through static facilities and community outreach programmes such as the Lady Health Worker programme. The MCH services, counselling on the full range of FP methods and provision of all short and long-acting reversible FP methods are part of primary health care. The *Sehat Sahulat*, the government's health insurance programme, provides antenatal, natal, and postnatal care services; FP counselling after delivery, long-acting reversible contraceptive services on-demand after delivery; in-patient treatment for post-abortion complications at the secondary level and above; and in-patient treatment for HIV/AIDS at the tertiary level.⁶

In Nepal, MCH, FP, and HIV services are part of primary health care and are offered free at the point of delivery to all citizens. Pre- and post-abortion counselling, management of post-abortion complications, comprehensive abortion services, including medical abortion and post-abortion contraceptive services, are also included. Additionally, the benefit package of the publicly operated health insurance programme titled "Social Health Security Program" includes

antenatal, delivery, and neonatal care; comprehensive abortion care; clinical investigations for HIV; and detection and management of cervical cancer.^{7,14} Insurees can access services from both government health facilities and listed private hospitals.⁷

In Bangladesh, ANC and PNC are provided at government-run health facilities at all levels, from primary to tertiary. Delivery care, including emergency obstetric and newborn care, is offered at secondary and tertiary levels. Contraceptive counselling and non-clinical methods, such as pills and condoms at a subsidised price, are provided under the Directorate General of Family Planning by dedicated FP workers at the community level. In contrast, clinical FP services are provided free of cost at the secondary level and above.¹⁵ Menstrual regulation is part of Bangladesh's national FP programme and provided at secondary and tertiary levels. Induced abortion is illegal in Bangladesh, except to save a woman's life.¹⁶

Some other aspects of SRHR as recommended by the Guttmacher-*Lancet* Commission, such as GBV and comprehensive sexuality education (CSE), are part of the programmes in some countries. India provides counselling on SRH at the community level through community health workers and at the Adolescent Friendly Health Clinics through adolescent, reproductive and sexual health counsellors.¹⁷ In Nepal, CSE is included in the national curricula for grades 6–10 under Environment Health and Population. It includes elements of reproductive health but not sexual health.¹⁸ The Ministry of Education, Government of Bangladesh, in collaboration with the World Bank, is implementing an age-appropriate CSE programme, the Adolescent Student Program, in select regions to address adolescent-specific challenges and also to expand the most successful modules of the intervention to all schools by 2022.¹⁹ Some of the services of the Guttmacher-*Lancet* Commission's list, however, are not included in the benefit packages of the government health services or publicly financed/operated health insurance programmes in these countries. Such services are prevention, detection, immediate services, and referrals for cases of sexual and gender-based violence; prevention, detection, and management of reproductive cancers; testing and treatment for infertility and subfertility; information, counselling, and services for sexual health and wellbeing.

Research agenda

We propose a set of priority areas where research is required to evaluate the effectiveness of currently included SRH services within UHC schemes. We have drawn upon well-accepted frameworks and approaches to UHC to make it easier for stakeholders to use. The first framework that national policymakers are familiar with is the “UHC cube” that measures the three dimensions of coverage, services covered, and financial protection.²⁰ The second framework was developed by the World Bank and World Health Organization² to track the progress of UHC at different levels (country or state), and the extent to which UHC is implemented with equity, service coverage, and financial protection offered. Our proposed priority research areas draw upon the WHO's list of 16 essential health services in four broad categories to measure progress toward UHC: reproductive, maternal, newborn, and child health; infectious diseases; non-communicable diseases; and service capacity and access.² The indicators around these categories are outcome-oriented and insufficient to measure the efficiency and effectiveness of how the existing UHC programs are being implemented.

Our research agenda includes two main components: (1) the three dimensions of UHC within which SRH is embedded, and (2) the gap between policy intent and implementation. We have listed illustrative research questions and the accompanying methodology and data sources for each component (Annexe 1).

The first UHC dimension of population coverage and equity may be assessed both in policies and under the scheme's implementation. The second UHC dimension of the service package may be assessed in terms of the select SRH services included as compared to the Guttmacher-*Lancet* Commission's expanded definition. We have also listed where the service would be rendered – inpatient/outpatient, primary, secondary, and tertiary level. We have highlighted the need and scope of research on the quality of services rendered. The third dimension assesses the extent to which UHC's financial protection intends to reduce OOP expenditure on SRH services. Specifically, it reviews the extent to which financing modalities such as community financing, community-based health insurance, conditional and unconditional cash transfers, voucher mechanisms, changes in user fees and result-based financing, publicly financed health insurance schemes, and public-

private partnerships (PPP) have reduced OOP expenditure for SRH services. We also emphasise assessing the proportion of the population expressing their ability and willingness to pay for SRH services and the proportion of enlisted/entitled population utilising or able to utilise specific schemes to avail SRH services. Our priority research areas further underscore how accountability for the policy and its implementation may be assessed.

UHC for SRHR: bridging the evidence gap

We present illustrative research questions under each of the three domains from the perspective of policy as well as implementation: population coverage with equity, service coverage, and financial protection. Policy documents outlining the scope of

Under population coverage and equity, it is important to know:

- *Are the programmes covering beneficiaries in actual need, or do some eligibility criteria exclude disadvantaged segments who need the programme?*
- *Are rural residents, economically disadvantaged populations, migrants, youth, and differently-abled persons covered under the programme?*

Desk review of policy documents, programme implementation plans, guidelines, government orders, meeting minutes, and reports published by the entity that designs and/or implements the programme could answer these questions of policy intent. To examine if the programmes are reaching the intended beneficiaries, we need to explore:

- *What proportion of the various population segments satisfy the eligibility criteria for availing the programme?*
- *What proportion of eligible individuals, who are supposed to be covered by the programme, could enlist themselves?*
- *What proportion of the population is accessing essential SRH services?*
- *Are the intended beneficiaries in different population subgroups accessing the services in equal proportions?*
- *Is there any gender inequity in terms of coverage?*

The methodologies that may help answer these questions include secondary analysis of population-level data (such as DHS), indirect estimates using programme monitoring data (such as HMIS, DHIS), community-level surveys, and interviews with beneficiaries.

SRHR components in the publicly financed programmes and their intended objectives of achieving UHC goals are available in each country. We recognise that despite policy commitments to UHC, significant disparities exist between the intent and actual implementation of policies. Assessing the implementation of the programmes is important for context-specific prioritisation of services and mechanisms for financial risk protection, and for building accountability mechanisms.

Under service coverage, integration of all the nine components of SRHR within UHC is limited. It is, therefore, important to explore the scope of the health benefits package of the programme. Some illustrative questions are:

- *What components of SRHR services, as per the Gutmacher-Lancet Commission, are covered or missing under the UHC programme?*
- *Other than FP, MCH, and HIV services, what are the preventive, promotive, curative, and rehabilitative services provided?*
- *Are the SRHR services that are not covered within the UHC programme being offered on a pilot/project basis or in a phased manner?*
- *What kind of care (in-patient/outpatient or primary/secondary/tertiary) is included?*

Available policy documents, programme documents, and interviews with policymakers and programme managers can help answer these questions. In terms of programme implementation, we need to know:

- *What components of SRHR services, as per the Gutmacher-Lancet Commission, are covered or missing during implementation?*

Programme monitoring data, community-level surveys, and evaluations can help answer this question. The other important issues to address under implementation include knowledge of entitlements and quality of services. For this, the research questions could include:

- *Do intended beneficiaries know about the SRHR services and associated components/benefits that are included and those that are not included in the UHC programme?*
- *Do intended beneficiaries know where and how to access services?*
- *What is the quality of care and services provided under the programme?*

Community-level surveys and quantitative and qualitative research among beneficiaries and providers can generate evidence to answer these questions.

Regarding **financial protection**, reducing OOP expenditure and ensuring that disadvantaged groups are not left behind in terms of accessing entitlements, it is important to examine:

- Which financing models – such as community financing and community-based health insurance; conditional and unconditional cash transfer; introducing, removing, or changing OOP costs or user fees; result-based financing, performance-based incentives, and social protection programmes that provide a voucher subsidy or subsidised products – have a greater potential to reduce OOP while ensuring sustainability?
- What are the mechanisms to make the system accountable for the implementation of the programme?

The key methodology is a desk review of policy documents, programme implementation plans, and guidelines and reports published by the entity that designs and/or implements the programme. From the implementation perspective, it is crucial to assess people's ability and willingness to pay:

- What proportion of the population expressed their willingness to pay, and what amount they were willing to spend for the services?

For service utilisation, we need to examine:

- What proportion of the enlisted/entitled population is utilising the benefits under the programme?
- What proportion of the population spends a large amount of household income on health?
- Are there differentials by gender, age, rural/urban, and other background variables?

For accountability of the system:

- Are there appropriately established mechanisms in place to assess and monitor the programme's functionality in terms of service coverage with quality and provision of grievance redressal?

Community-level surveys, a survey among the entitled population/beneficiaries, concurrent assessment of programme monitoring data, evaluations based on cost-effectiveness and cost-benefit analysis of various interventions and government investments can help answer these questions.

PPPs in SRHR are being considered as an avenue to garner resources for the healthcare systems while enhancing access to underserved and disadvantaged people. These countries have explicitly included the private sector as a key partner in improving access to select SRH services. The PPP

model can be explored to include some reproductive health services, including, but not limited to, infertility management and cervical cancer treatment that have so far not been covered under the existing UHC programmes in these countries. For example, certain aspects of cervical cancer management are linked with primary care and can include screening at the health facility level, and human papilloma virus (HPV) vaccination. PPP can also strengthen self-care innovations as a means of expanding population and service coverage. For instance, people can use at-home self-testing sample collection kits for HPV, and pregnancy tests or ovulation kits as part of self-testing as part of infertility management. Such kits, vaccines, or chemicals/commodities are manufactured by private companies. If they join hands with the public sector, services could be offered at a subsidised rate for disadvantaged populations. It is, however, important to assess the effectiveness of PPP models in reaching underserved populations.

Ways to strengthen monitoring, evaluation, and learning related to programme implementation

Generating evidence on the implementation of a UHC programme depends on robust data collection and monitoring systems, evaluation mechanisms, and prioritising resource allocation for evidence generation. However, existing systems, mechanisms, and processes, with some adaptation and innovation based on learnings across countries, can facilitate answering some key research questions.

Some adjustments can be made with minimal additional resources and can produce valuable data. For example, an integrated data system is necessary to monitor whether a programme is moving toward the UHC goal of population coverage, with an equity, gender and intersectionality lens.^{21,22} *This can be done by linking existing programme monitoring databases (such as HMIS) with unique identification databases and/or other linked datasets that include critical, previously uncollected cross-cutting variables (e.g. gender, disability status, socio-economic status, and ethnicity).* India's PM-JAY that linked the programme's access-related information with the user's universal identification codes is a good example that can be replicated in other settings for assessing a programme's reach from an equity lens.

Governments, researchers, and programmers should leverage and analyse nationally

representative sample survey data on health such as the Demographic Health Surveys (DHS) or the Multiple Indicator Cluster Surveys (MICS). This will help gain insights into beneficiary coverage, equity, knowledge, and use of SRH services. The numbers of sampled households in DHS datasets for India and Pakistan are sufficiently large to analyse intersectionality. Additionally, analysis of expenditure incurred on various SRH services can help assess the extent to which the UHC programme ensures financial protection for underserved/marginalised populations. We suggest that *the DHS or MICS include a module on health expenditures, especially collecting data on OOP spending on SRH services.*

Before implementing any programme at scale toward achieving UHC, the programme's pilot phase should include rigorous impact evaluations examining inequities in population and service coverage and utilisation. Doing so will help identify areas where programming needs to be strengthened such that the intended impacts can be achieved. We suggest that the programmes plan for a *built-in rigorous impact evaluation (e.g. randomised control trials, quasi-experimental designs, and stepped-wedge embedded research design) at the design stage, and to allocate the required resources.* After analysing programme monitoring data, to assess why, how and for whom certain monitoring system results were not as expected, *plan for mixed-method studies including targeted community-level surveys and qualitative studies. Such studies can help gain insights into improving equitable access to SRH services, barriers, and bottlenecks to improving coverage and challenges to financial protection on the road to UHC.* For example, between 2009 and 2014, the Directorate General of Health Services, Ministry of Health and Family Welfare of Bangladesh commissioned a rigorous quasi-experimental evaluation of its reproductive health vouchers programme during its third phase.²³ This evaluation included quantitative and qualitative studies that assessed the programme's impact on improving access to and quality of safe motherhood and FP services and reducing inequities. Evidence from the study was utilised to improve the expansion of the voucher programme in Bangladesh in subsequent phases.

Accountability mechanisms can be enhanced by including mechanisms for routine beneficiary/user feedback to gauge key UHC parameters such as service coverage, level of financial protection received, and quality of and satisfaction with services. We

suggest *using digital technology such as mobile applications to ascertain user experience with programmes.* The growing use of mobile phones is remarkable and is diminishing the inherent rich-poor gap. Although gender-based inequities in access to digital technology exist in South Asia – in 2020, the gender-gap in mobile phone ownership was 19%, and the gap in mobile internet-use was 36% – these gaps are reducing.²⁴ Considering the large proportion of households that has access to mobile technologies in this region, mobile applications could be an effective means of collecting such information from beneficiaries, even among the poorer households. Women beneficiaries without access to digital technology could be reached through the mobile phones of the frontline health workers in their areas. Such data should be seamlessly linked with government health bodies and mechanisms to inform accountability mechanisms and achieve UHC.

Call to action

This commentary notes that only select SRH services around MCH, FP, HIV, and post-abortion care are included under government health services or publicly financed health insurance programmes in the four South Asian countries that we examined. The expansion of service coverage needs to involve key SRHR stakeholders, especially the healthcare providers, in the policymaking process. The supply-side issues have already been documented and experienced by the healthcare providers in several pilots and publicly financed insurance programmes. Lessons should be incorporated into policymaking and the process of designing the programmes. Multifaceted challenges are involved in getting SRHR on the UHC agenda. One of the biggest challenges to the convergence of all components of SRHR into a single UHC programme is that many of these components are currently being implemented by various ministries/departments of the government other than the Department of Health. For example, sexuality education may be covered by the Department of Education under their school health or adolescent health programme. The management of GBV may be covered under the Department of Women and Child Development.

Process evaluation helps assessing programme design or development as well as implementation strategies. Routine and rigorous assessments using programme monitoring data, leveraging existing

large-scale surveys or through community-based surveys, rarely take place. This is true even for the limited range of SRH services currently included under the programmes aiming to achieve UHC.

This commentary focuses on population and service coverage, and implementation of government-run primary healthcare services and publicly financed health insurance programmes. We have not dealt with other existing financing mechanisms that contribute to achieving UHC in these countries. However, we posit that a similar analytical frame can be used to assess their effectiveness.

We underscore that SRHR is not included to its full extent in UHC in the South Asian countries examined in this commentary. The input of SRHR stakeholders, including practitioners and hospital managers, in the UHC policymaking process is imperative, and therefore, we urge bringing them to the same table with UHC decision-makers. We believe that the availability of timely evidence can empower decision-makers to ensure the progressive attainment of SRHR in UHC. We recommend having built-in robust monitoring, evaluation, and learning systems as part of the programme evaluation design. This can help in iterative programme improvement through coherent use of routine service data. A commitment toward monitoring programme implementation and using the generated evidence in decision-making will be beneficial. High-quality data can inform policy decisions to expand SRHR services beyond FP, MCH, and HIV to include gynaecological cancers, sub-fertility and infertility, GBV, and other neglected areas. Establishing a national research forum with *broad participation of SRHR and UHC stakeholders from both public and private sectors along with civil society*

organisations can suggest ways to utilise the generated evidence toward progressive realisation of UHC. We also envisage that research gaps can be addressed with adaptations to existing data collection mechanisms and/or cost-effective solutions.

Acknowledgement

We acknowledge Irfan Hossain, Population Council, Bangladesh for providing necessary information and Ali Mohammad Mir, Population Council, Pakistan for reviewing an initial draft. We thank Reeti Mathur for copyediting the manuscript. Sincere thanks to the Editor and reviewers for their excellent reviews that strengthened the commentary.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Supplemental data

Supplemental data for this article can be accessed at <http://dx.doi.org/10.1080/26410397.2022.2040775> description of location.

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