Indicator name
Number of women, men, adolescents, in all their diversity, with increased access to sexual and reproductive health care and services
Aggregable indicator
Yes
Indicator type (quantitative/qualitative)
Quantitative
Thematic area of engagement
Promoting sexual and reproductive health and rights
Related objectives in the Gender Action Plan III
Overall thematic objective: Women and girls in all their diversity access universal health and fully enjoy their health and sexual and reproductive rights **Specific thematic objective 2:** Improved access for every individual to sexual and reproductive health care and services, including family planning services, information and education on sexual and reproductive rights
Technical Definition

This indicator intends to measure how many women, men and adolescent girls and boys have increased access to sexual and reproductive health care and services.
 	
The following definitions apply:
 	
- Sexual and reproductive health care[1] is a state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:
  o have their bodily integrity, privacy, and personal autonomy respected;
  o freely define their own sexuality, including sexual orientation and gender identity and expression;
  o decide whether and when to be sexually active;
  o choose their sexual partners;
  o have safe and pleasurable sexual experiences;
  o decide whether, when, and whom to marry;
  o decide whether, when, and by what means to have a child or children, and how many children to have;
  o have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.
- Sexual and reproductive health services[2] must meet public health and human rights standards, including the "Availability, Accessibility, Acceptability, and Quality" framework of the right to health.[3] The services should include:
  o accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education;[4]

[1] The Lancet Commissions (2018): Accelerate progress - sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. Lancet 2018; 391: 2642–92
[2] *Ibidem*
[3] WHO (2017): Leading the realization of human rights to health and through health

- information, counselling, and care related to sexual function and satisfaction;
- prevention, detection, and management of sexual and gender-based violence[5] and coercion;
- a choice of safe and effective contraceptive methods;[6]
- safe and effective antenatal, childbirth, and postnatal care;[7]
- safe and effective abortion services and care;
- prevention, management, and treatment of infertility;[8]
- prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections;[9] and
- prevention, detection, and treatment of reproductive cancers.[10]

Rationale

Sexual and reproductive health and rights (SRHR) refer to the right of every individual to have full control over, and decide freely and responsibly on matters related to their sexuality and sexual and reproductive health, free from discrimination, coercion and violence. In humanitarian situations and fragile contexts - either due to war and conflicts or to climate and economic crises - barriers to health care and SRHR services, along with the persistence or exacerbation of harmful social norms that oppose the right to bodily autonomy and choice, expose populations, particularly the most disadvantaged, to serious discrimination and violation of their rights. Access to high-quality, affordable sexual and reproductive health services and information, including a full range of contraceptive methods, is fundamental to realising the rights and well-being of women and girls, men and boys, in all their diversity.

The EU is committed to the promotion, protection and fulfilment of SRHR in the framework of the full and effective implementation of the Beijing Platform for Action and the Programme of Action of the International Conference on Population and Development (ICPD) and the outcomes of their review conferences. The EU further stresses the need for universal access to quality and affordable comprehensive sexual and reproductive health information, education, including comprehensive sexuality education, and health-care services.[11] Through GAP III specific area of engagement on SRHR, the European Commission and the High Representative committed to support transformative actions for gender equality, e.g., multi-country partnerships in Sub-Saharan Africa to address SRHR, among others.

Data source and calculation

Reporting covers cooperation, development and humanitarian (if applicable) initiatives and investment frameworks funded by the EC (INTPA, NEAR, FPI, ECHO) and EEAS.

EUMS may provide information related to their interventions through their contributions to GAP III reports or through the EUDs, e.g., in cases of joint dialogue (i.e., as part of joint programming or TEI).

Data sources:

The intervention's monitoring and reporting systems, e.g., inception, interim and final reports from implementing organisations (including governments, international organisations, national and international civil society organisations, private sector, etc.), ROM reviews and evaluations.

Administrative records from health centres, hospitals, and SRHR services within the scope of the EU action/intervention as well as the data available at the Ministry/regional department of Health/Women's

[4] See UNFPA resources: Adolescent sexual and reproductive health; WHO Recommendations on adolescents sexual and reproductive health and rights
[5] See OHCHR, Gender-based violence
[6] See UNFPA, Family Planning
[7] See WHO, Regional Office for Europe, Maternal and newborn health
[8] See WHO, Infertility
[9] See WHO, Sexually transmitted infections (STIs)
[10] See WHO, Cervical cancer
[11] The EU New Consensus for Development. "Our world, our dignity, our future".

Affairs/Education and the national/regional statistics offices.

Surveys/interviews conducted and budgeted by the intervention can also be relevant data sources.

Baseline and endline studies conducted and budgeted within the EU intervention. These studies can be conducted as part of the gender country profile and/or gender sector analysis, or be based on existing official reports and published data. Baseline and endline studies should be conducted using the same data collection methodology.

Calculation:

Single women, men, adolescent girls and boys with increased access to sexual and reproductive health care and services need to be counted.

Each individual (disaggregated as below) benefiting from different services thanks to the EU supported intervention should be counted separately and only once if they benefit from more than one intervention of the same type (e.g. different phases of the same programme).[12]

In particular, to avoid double counting, a peak year result should be taken, i.e., by reporting the highest number of people who benefited from the EU intervention on a yearly basis. Results on a multi-year basis will be calculated by adding the number of new individuals reached in years 2, 3, etc. to the total reached in year 1. In case of interest and if possible, it can also be calculated the number of beneficiaries by typology of services, e.g. information and counselling, prevention, detection and treatment of different illnesses, etc.

Worked examples

In country A, the EU supports UNFPA and civil society organisations to improving access to SRHR. Three initiatives were implemented to:

(1) Increasing maternal and new-born child health centres in the North-East governorates.
(2) Preventing and treating sexually transmitted infections (STIs), including HIV, and of reproductive tract infections.
(3) Increasing sexuality education for adolescent girls and boys.

- ⇨ (1) 158 pregnant women and 136 new-born babies (72 females and 64 males) were assisted by skilled personnel.
- ⇨ (2) 380 people (200 men and 180 women, out of whom 120 young men and 115 young women aged 16-24) were sensitised on how to prevent STIs; 10 people (including 5 women aged 25-64, 3 young men aged 16-24 and 2 men aged 25-64) received HIV care and treatment.
- ⇨ (3) 28 schools in 5 governorates implemented a campaign on adolescent sexuality education: A total of 12.000 adolescents were targeted, including 6.200 adolescent girls and 5.800 adolescent boys aged 10-17.

Baseline

Data from official counterparts (i.e., national women's machinery, national gender observatories, ministries of health/education, health and education centres, statistical institutes, etc.). Data from international and national organisations working on SRHR or other independent non-state actors.

If baseline data are lacking, a mapping can be done at the start of the intervention using surveys/ interviews.

[12] Avoiding double counting is especially relevant when aggregating values of different indicators. As a general rule, it is acceptable to record the same individuals under different indicators and between different interventions if the EU funds different services (i.e., a child under one receives nutrition in the framework of one intervention and is also immunised in the framework of another intervention). Where an individual receives the same service in the framework of the same EU supported intervention (e.g., different phases of a nutrition programme), this cannot be matched to different indicators and between different interventions.

The baseline can be 0 when the indicator is achieved with the EU funded intervention.
Disaggregation
Baseline, periodic and endline surveys targeting women and girls, men and boys. If the collection of information is part of a broader survey, data need to be disaggregated by age[13] as a minimum, and by gender[14] and disability status, whenever possible. As a person's gender identity does not necessarily equal nor can it be deduced from their sex, for international and national reporting it is recommended, whenever possible, to collect data disaggregated by gender. Taking into due account the "do no harm" principle, it is also recommended to collect data on other intersecting grounds of potential discrimination (e.g., geographical location, population group - ethnic minority, linguistic or religious group member- socio-economic situation, migration status, etc.) based on relevance to the intervention and availability of data. Data disaggregation to capture the intersecting dimensions of each person reporting is necessary to increase the quality and effectiveness of programmes, projects, and dialogue, and make visible the experience of different individuals. The collection, analysis and use of disaggregated data is a priority, regardless of previous practice. Due consideration should be paid to national data collection capacity. Furthermore, those in charge of data collection need to assess carefully if and how to collect sensitive data, for example, concerning sexual identity and the legal situation in the national context to avoid harm to individuals or groups by revealing characteristics they carry.
Availability and Timeliness
Information should become available annually, depending on the duration of the intervention.
Related DAC CRS code
122 – Basic Health / 12220 - Basic health care / 12230 - Basic health infrastructure / 12240 - Basic nutrition / 12250 – Infectious diseases control / 12261 - Health education / 12281 – Health personnel development / 123 Non-communicable diseases (NDCs)/ 12310 – NDCs control, general / 12350 - Other prevention and treatment of NCDs 130 – Population Policies/Programmes & Reproductive Health / 13010 - Population policy and administrative management / 13096 - Population statistics and data / 13020 - Reproductive health care / 13040 - STD control including HIV/AIDS / 13081 - Personnel development for population and reproductive health
Associated SDGs
SDG 3 Ensure healthy lives and promote well-being for all at all ages Target 3.1, Indicator 3.1.1 (see Metadata) Target 3.2, Indicator 3.2.2 (see Metadata) Target 3.3, Indicators 3.3.1 (see Metadata), 3.3.4 (see Metadata) Target 3.4, Indicator 3.4.1 (see Metadata) Target 3.7, Indicators 3.7.1 (see Metadata), 3.7.2 (see Metadata) Target 3.8, Indicator 3.8.1 (see Metadata) SDG 5 Achieve gender equality and empower all women and girls. Target 5.1, Indicator 5.1.1 (see Metadata) Target 5.2, Indicator 5.2.2 (see Metadata) Target 5.3, Indicators 5.3.1 (see Metadata), 5.3.2 (see Metadata)

[13] Age groups: 0-15; 16-24; 25-54; 55+
[14] Gender encompasses a person's identities, expressions, and societal roles (man, woman, non-binary, other options)

Target 5.6, Indicators 5.6.1 (see Metadata), 5.6.2 (see Metadata) Target 5.c, Indicator 5.c.1 (see Metadata)
Other issues
The gender country profile and/ or gender sector analysis can be relevant sources of information for establishing baselines. If there is no gender analysis available at the EUD, it is recommended to look at the analysis undertaken by EU Member States or other trusted partners (UN, World Bank, human rights national and regional mechanisms, etc.) as well as the national-level reviews carried out in 2019 by UN Women and the partner countries to assess progress made and challenges encountered in the implementation of the Beijing Declaration and Platform for Action. Special attention should be paid to following up on partner country institutions reached with EU support.