

A Comparative Analysis of Sexual and Reproductive Healthcare Across the United States, Spain,
and South Africa

Adelaide McLain
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ABSTRACT

The aim of this study was to identify the main causes for negative sexual and reproductive health (SRH) outcomes within the United States. The sexual and reproductive healthcare system of the United States was compared with that of Spain and South Africa. Health insurance barriers, as well as inconsistent SRH education, were identified as two major sources for poor SRH outcomes in the USA. Telemedicine, nationally mandated SRH education, subsidized SRH resources, and the implementation of new frameworks were discussed as possible solutions.

INTRODUCTION

In 2022, healthcare spending accounted for 17.3% of the American GDP with an average spending of \$13,493 per person (Centers for Medicare and Medicaid Services, 2024). With such a high cost for healthcare, many Americans are beginning to question national health outcomes such as the 2020 maternal mortality ratio of 21.1 per 100,000 women, compared to the Organization for Economic Cooperation and Development (OECD) average of 10.9 per 100,000 women (OECD, 2023). Maternal mortality typically serves as an indicator for the overall sexual and reproductive health (SRH) of a country. As a world leader in medicine, why is the United States struggling in sexual and reproductive health?

According to the World Health Organization, in 2024 there were 77,692,170 women of reproductive age (ages 15 through 49) in the USA. This indicates that 23.04% of the total population of the United States is directly impacted by access to sexual and reproductive healthcare. Additionally, the total fertility rate is 1.62 meaning that on average, an American woman has 1.62 children if she lives to the end of her childbearing years (WHO, 2024). A comprehensive analysis of the United States sexual and reproductive healthcare system, in contrast with other developed countries, is critical for the domestic advancement of women's health which impacts such a large population.

There is a gap in the literature in terms of studies that compare SRH policies and outcomes of the United States with that of other countries in order to understand the domestic causes for negative SRH outcomes. This study analyzes the sexual and reproductive healthcare systems of Spain and South Africa as they are located in different parts of the world, with unique global contexts. Through this comparison, methods for the domestic improvement of sexual and reproductive healthcare are identified and potential solutions are discussed.

LITERATURE REVIEW

The United States, being a developed nation with a robust healthcare system, has unusually poor sexual and reproductive health outcomes. These include high rates of maternal mortality, infant mortality, and teen pregnancies as compared to other developed nations. Additionally, some minority groups experience significantly worse SRH outcomes. For example,

infant mortality rates for black women are significantly higher across the country as compared to the national average (Callaghan, 2014). One study suggests that for low-income women in the United States, the negative SRH outcomes can be attributed to insurance barriers, treatment by medical staff, and lack of education regarding available resources (Zimmerman, 2017). For many patients, healthcare is inaccessible due to the high cost of insurance, which is only further complicated for individuals without documentation who cannot register for health insurance. Many low-income women feel a distrust for clinical staff or feel that they will be treated unfairly during their appointment. Additionally, a significant portion of women nationwide do not understand what resources are available to them or how to access the care that they need. In general, women of marginalized communities are less likely to receive sexual and reproductive healthcare services and are more likely to experience negative SRH outcomes.

Other research has argued that reproductive health outcomes in the United States are driven by state legislation regulating access to reproductive healthcare (Bossick et al., 2021). While this is an emerging area of research, it is widely known that many states, such as California and New York, have policies that guarantee widespread access to abortion services. Other states, such as Texas and Mississippi, currently have restrictive bans on all abortion services (Center for Reproductive Rights, 2024).

Fullman et al. (2018) provides one of the largest comprehensive measures of overall healthcare through a global Healthcare Access and Quality (HAQ) index comparing 195 countries and territories. This study assessed index deciles of 82.2-91.3% for the United States, >91.3% for Spain, and 44.8-54.7% for South Africa, based on generalized healthcare. Specific ratings for 32 different health indicators are also included, some of which are relevant to SRH. The United States scored 81 for maternal disorders, 67 for neonatal disorders, and 100 for breast cancer. Spain scored 100 for maternal disorders, 88 for neonatal disorders, and 84 for breast cancer. South Africa scored 42 for maternal disorders, 30 for neonatal disorders, and 62 for breast cancer (Fullman et al., 2018). While this study provides valuable information about health outcomes on a global scale, it does not specifically address SRH or attempt to answer why countries such as the United States have the health outcomes shown. Overall, there is a shortage of studies using in-depth comparative analysis of the policies, SRH outcomes, and successes of other countries to improve the sexual and reproductive healthcare system of the United States.

While much is being studied to understand SRH outcomes within the context of the United States, analysis within a global context is equally important. By comparing the sexual and reproductive healthcare system of the United States with that of other nations, potential areas of improvement can be more accurately identified. This study aims to expand upon current theories by comparing the sexual and reproductive healthcare system of the United States with that of Spain and South Africa. This lens allows for the identification of key factors affecting SRH outcomes within the United States.

BACKGROUND

According to the World Health Organization (WHO), “[s]exual and reproductive health services include: modern contraception; the prevention and management of STIs and cervical and other reproductive cancers; safe abortion; the prevention and treatment of gender-based violence; and infertility services” (WHO, 2020). The Coalition to Expand Contraceptive Access, a research institute in California, proposed two frameworks with the intention of improving existing sexual and reproductive healthcare by broadening the definition to include patient wellbeing and health equity. The first relevant definition is sexual and reproductive health wellbeing (SRHW) which is “a self-defined state that includes reaching one’s individual sexual and reproductive goals” (Hart et al., 2022). The second framework is based on sexual and reproductive health equity (SRHE) which “means that systems ensure that all people, across the range of age, gender, race, and other intersectional identities, have what they need to attain their highest level of sexual and reproductive health, and includes self-determining and achieving their reproductive goals” (Hart et al., 2022). These frameworks are useful for analyzing existing national policies and in determining suggested areas of improvement within the United States.

According to a WHO 2018-2019 policy survey (2020), 94% of countries have a national policy covering reproductive healthcare. However, only 39% of countries have comprehensive policies that include all the SRH topics outlined by the WHO. It is crucial that national SRH policies include all relevant aspects to improve health outcomes overall. Interestingly, the United States does not have a singular, national SRH policy that contains all the topics listed above. While various policies exist covering one or two of these areas outlined by the WHO, an all-encompassing document could not be identified for the USA.

Table 1. Background sexual and reproductive health data for the USA, Spain, and South Africa.

	USA	Spain	South Africa
2024 Women of reproductive age (15 - 49 years) as % of total population	23.04%	21.26%	28.20%
2024 Total fertility rate (live births per woman)	1.62	1.22	2.21
2024 Contraceptive prevalence - any modern method (among women aged 15 - 49 years)	67.30%	62.20%	58.50%
2024 Proportion of women of reproductive age (aged 15 - 49 years) who have their need for family planning satisfied with modern methods	82.30%	81.80%	80.60%
2020 Maternal mortality ratio (per 100,000 live births)	21.08	3.44	126.83
2022 Neonatal mortality rate (per 1,000 live births)	3.17	1.72	11.02
2024 Adolescent birth rate (per 1,000 females aged 15 - 19 years)	N/A	4.85	51.84
2016 Proportion of births attended by skilled health personnel	N/A	N/A	96.70%

Notes: Compiled by author using data from World Health Organization (2024).

Table 1, seen above, was compiled using data from the WHO maternal, newborn, child and adolescent health and ageing data portal (2024). As seen in Table 1, the United States leads both Spain and South Africa in contraceptive prevalence (67.30% among women aged 15 - 49 years) and the proportion of women of reproductive age (aged 15 - 49 years) who have their need for family planning satisfied with modern methods (82.30%). Although these statistics may suggest that the USA is succeeding in providing SRH services, many national SRH outcomes indicate quite the opposite. According to Table 1, the maternal mortality ratio in the United States was 21.08 for every 100,000 live births (2020) while the neonatal mortality rate in the United States was 3.17 for every 1,000 live births (2022). According to the National Conference

of State Legislatures (2020), “Though the teen birth rate has declined to its lowest levels since data collection began, the United States has the highest teen birth rate in the industrialized world.” This report seeks to understand what is driving the negative SRH outcomes in the United States.

Spain is a medically advanced nation with a comprehensive SRH policy. As seen in Table 1, as of 2024, women of reproductive age comprise 21.26% of the Spanish population with a total fertility rate of 1.22. Spain was reported to have a contraceptive prevalence of 62.20% among women aged 15 - 49 years. The proportion of Spanish women of reproductive age who have their need for family planning satisfied with modern methods is 81.80%. Despite having less contraceptive use and less widespread family planning access than the United States, Spain had a significantly better maternal mortality ratio (3.44 per 100,000 live births in 2020) and a better neonatal mortality rate (1.72 per 1,000 live births in 2022).

South Africa is a developing nation with a robust healthcare system and a comprehensive SRH policy. As of 2024, women of reproductive age comprise 28.20% of the population of South Africa with a total fertility rate of 2.21. According to Table 1, in 2024, South Africa was reported to have a contraceptive prevalence of 58.50% among women aged 15 - 49 years, which is almost 10% lower than the USA. The proportion of South African women of reproductive age who have their need for family planning satisfied with modern methods is 80.60%. The maternal mortality ratio in South Africa was 126.83 per 100,000 live births in 2020 while the neonatal mortality rate was 11.02 per 1,000 live births in 2022, both of which are significantly higher than the USA and Spain. Finally, as of 2016, 96.70% of births in South Africa were attended by a skilled health professional. South African policies encourage widespread use of SRH resources, extending this access to children as well. At the age of 12, South African children can access contraceptives, HIV testing, and termination of pregnancy, without the consent of their parents (Strode & Essack, 2017).

RESEARCH METHODS

The purpose of this analysis was to identify the main factors affecting SRH outcomes within the United States, through comparison with the sexual and reproductive healthcare systems of Spain and South Africa. Mixed methods were used including content analysis of policy documents, quantitative data, and personal observations from travel experiences.

The frequency distribution of key words in selected policy documents was analyzed to determine the SRH priorities of each country. Much of the quantitative data available for this study came from the Center for Disease Control (data for the United States) and the World Health Organization (global data) which was used to support the findings from the policy document analysis. This data was supplemented with qualitative sources such as national reports, national policies, and online articles.

Anecdotal evidence was integrated into the results section from personal observations made while traveling and living in these three countries, such as observations of available healthcare resources and cultural contexts. As a woman who is interested in the field of medicine, I have spent years observing the sexual and reproductive healthcare system of the United States. In the summer of 2023, I visited Johannesburg, South Africa and spent time with a community in Soweto, a township of immigrants and low-income individuals living directly outside of the wealthy Johannesburg neighborhoods. From January to May of 2024, I lived in Valencia, Spain and participated in a course centered on the Spanish healthcare system. In both South Africa and Spain, I made direct observations of the sexual and reproductive healthcare systems which inspired my research.

One purpose of the policy document analysis was to identify the SRH priorities of each country. Three documents were analyzed: the Affordable Care Act (2010) for the United States, Estrategia Nacional de Salud Sexual y Reproductiva (2011) for Spain, and National Integrated Sexual and Reproductive Health and Rights Policy (2019) for South Africa. The documents for Spain and South Africa were selected because they are policies directly outlining the national sexual and reproductive health markers and strategies for improvement. A policy document focused solely on addressing SRH outcomes and policies could not be located for the United States, so the Affordable Care Act (ACA) was chosen. The ACA qualified for this study as a

national policy that addresses SRH issues along with outlining plans for guaranteed access to SRH resources, although many other topics are addressed in the document as well.

A word count was conducted as part of the policy document analysis to understand the overall content of each document. The words chosen were pulled from the WHO definition of SRH (“Contraception”, “STI”, and “Abortion”), from topics relevant to SRH services (“Education”, “Insurance”, “Cost”, “Affordable”, “HIV”, “Pregnancy + Birth”, and “Access”), and from the SRHW and SRHE frameworks (“Wellbeing” and “Equity”). A count was conducted to determine the number of times that each word appeared in each document. This data was then standardized to determine the frequency with which each word appeared per page, for each document. In Figure 1, the x-axis label “Insurance + Cost” also incorporates the key word “Affordable” which did not fit in the figure.

Quantitative data from the National Conference of State Legislatures (NCSL) and the Centers for Disease Control and Prevention (CDC) were analyzed to understand SRH education requirements and teen birth outcomes within the United States. The NCSL reports on the requirements for sexual health education in various states (2020). The educational requirements selected were predetermined by the source. The four states selected for comparison were chosen because two are currently liberal (Colorado and California) while two are historically conservative (Texas and Arizona). While Colorado used to be a conservative state, it has become liberal in recent history and is classified as such for the purposes of this research. The CDC provided quantitative data on the 2022 teen birth rates for all four states, as well as the national average (2022, 2024).

Spain and South Africa were intentionally selected for comparison with the United States. Both countries have robust, stable, and organized healthcare systems that are comparable to that of the United States. According to the United Nations (2020), South Africa is still a developing nation while Spain and the United States are developed nations. Spain has implemented a universal healthcare system, South Africa has recently signed into law its own universal healthcare system (Baugh, 2024), and the United States does not have a universal healthcare system. The United States, Spain, and South Africa are all located on different continents, operating in very different global contexts. The United States government is significantly more decentralized than either of the other two countries. The policies and

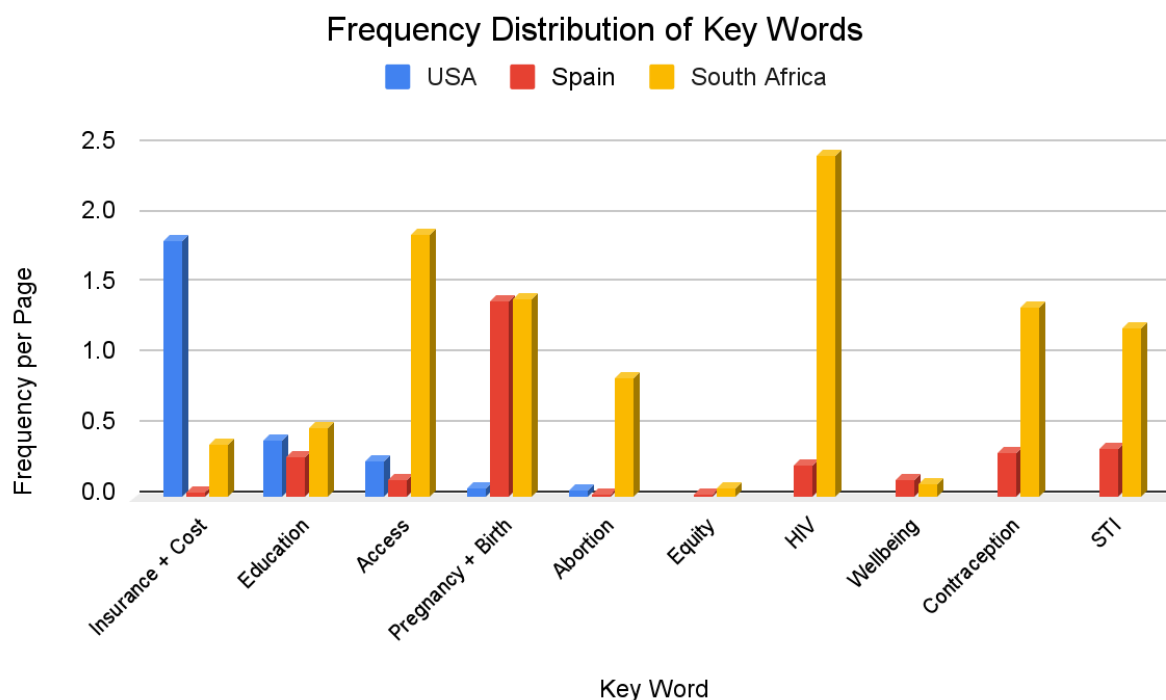
programs generated at the state level have a significant impact on the variation in healthcare offered between different states in the US.

RESULTS

i. Policy Document Analysis Across United States, Spain, and South Africa

Content analysis of policy documents was used to understand the SRH priorities of the three chosen countries, which is illustrated in Figure 1. The words “insurance”, “cost”, and “affordable” are mentioned in the Affordable Care Act (ACA) with greater frequency than any of the other words analyzed. Collectively, these words were used an average of 1.83 times per page throughout the 906 page document. Insurance, and the cost of healthcare, are discussed frequently throughout the ACA as the document outlines a national health insurance plan to lower the cost of healthcare for Americans. The word “affordable” appears in this document to describe the goals laid out by the national government and the requirements at the state level to achieve these goals. For example, “No later than July 1, 2010, the Secretary, in consultation with the States, shall establish a mechanism, including an Internet website, through which a resident of any State may identify affordable health insurance coverage options in that State” (ACA, 2010). The word “access” appears an average of 0.25 times per page as the document aims to expand access to health insurance for Americans. Words such as “wellbeing” and “equity” were used less than 0.01 times per page in sentences such as “the equity of health services and health disparities across health disparity populations... and geographic areas” (ACA, 2010). As a document that primarily addresses health insurance, the ACA discusses cost, access, and insurance coverage significantly more frequently than it addresses SRH resources such as contraception and abortion, or patient satisfaction and wellbeing. In the United States, the health insurance system limits access to healthcare for a large population. Whether it is the cost of health insurance, the complexity of the system, the limited coverage of many policies, or undocumented immigrants being ineligible for insurance, this barrier has created gaps in SRH outcomes.

Figure 1. Frequency distribution analysis of key words in national SRH policies.



Notes: Created by the author using the Affordable Care Act (2010), la Estrategia Nacional de Salud Sexual y Reproductiva (2011), and the National Integrated Sexual & Reproductive Health and Rights Policy (2019). The x-axis label “Insurance + Cost” includes the word “Affordable.”

As someone who is interested in joining the field of medicine, I have shadowed various physicians and gained insight into the current challenges facing the United States healthcare system. I have observed that one of the greatest barriers that physicians face when it comes to providing quality care, is health insurance. Oftentimes, a physician wishes to prescribe a medication but is unable because it will not be covered by the patient’s health insurance company. Additionally, many patients delay seeking treatment because they fear the financial repercussions of seeking medical attention. For patients completely lacking health insurance, due to unemployment or undocumented status, SRH outcomes are dramatically worsened. This observation agrees with a study conducted in the United States, which found that compared to young women who were continuously insured throughout the last year, those who had no insurance were 56% less likely to have had a gynecological exam and 36% less likely to have used a prescription contraceptive. Compared to the continually insured group of young women, those with insurance coverage for only part of the year were 31.5% less likely to have had a

gynecological exam and 36.5% less likely to have used a prescription contraceptive (Kerber & Pinchak, 2022). Difficulty accessing health insurance creates a barrier, preventing women across the country from accessing SRH resources.

In Spain, health insurance does not affect health outcomes as drastically as in the United States. Having implemented a universal healthcare system, Spain provides SRH resources to all citizens, as well as to many immigrants. One study reports that “[t]he integration plan focus[es] on accessibility and mentions two general objectives: guaranteeing the right to health for foreigners and improving the diversity management capacity of health centres” (Ledoux et al., 2018). While living in Spain, I was shocked to learn that undocumented immigrants could access medical treatment, and that health insurance was not a barrier to care for any citizen. As each Spanish citizen is covered by the national health system, every woman has access to the SRH resources that they need, without having to weigh the cost. Co-pays for medications are largely subsidized by the government, if not covered completely. This national health system is funded by taxes, leveling the healthcare market and providing equal access to all citizens. Figure 1 illustrates that in the Spanish SRH policy document, the words “insurance”, “cost”, and “affordable” were collectively used infrequently at 0.03 times per page. Words such as “pregnancy”, “contraception”, and “STI” were utilized regularly throughout the document as policies and national guidelines were outlined. Interestingly, the word “wellbeing” appeared 0.13 times per page. As the national healthcare system provides for the costs of each Spanish citizen equally, this SRH policy document focuses significantly more on SRH resources, as well as patient wellbeing.

South Africa, having recently signed into law a universal healthcare system, focuses more attention on the resources required by the South African population than on the costs associated. As seen in Figure 1, the South African SRH policy document includes the words “HIV”, “access”, “pregnancy”, “contraception”, and “STI” extensively as it discusses methods of improving national SRH outcomes. Words such as “insurance”, “cost”, and “affordable” are used significantly less frequently. Additionally, the words “equity” and “wellbeing” are used least frequently out of any of the words analyzed. While in Soweto, I visited a one-room daycare center where 15 toddlers were playing and being looked after. The purpose of this daycare was to allow the young mothers of these toddlers to attend middle school as they were approximately 13 years old. As seen in Table 1, only 58.50% of the women of reproductive age in South Africa are

using contraception (WHO, 2024). Today, the major SRH issues requiring national attention are teen pregnancy and STI/HIV rates. As I continued walking through Soweto, I passed a Red Cross tent offering free HIV testing and medication. As the South African government tackles teen pregnancy and HIV/STI rates, their focus on providing SRH is reflected in the SRH policy document analyzed. As mentioned in the background section, individuals as young as 12 years old have access to contraception, HIV testing, and abortion services, without barriers such as parental consent (Strode & Essack, 2017). Regardless of the costs, the South African government is aiming to improve SRH outcomes across the country.

ii. Sexual and Reproductive Health Education

One plausible explanation for the negative SRH outcomes in the United States is the variable SRH education across the country. Negative health outcomes, such as teen pregnancies, are improved through appropriate implementation of SRH education programs that encourage contraceptive use. The Centers for Disease Control and Prevention (CDC) reports that in 2022, the teen birth rate for the United States was 13.6 births per 1,000 teenage girls (2024). While this shows a decline from the 62 births per 1,000 teenage girls in 1991 (CDC, 2024), this rate is still significantly higher than that of developed countries, such as Spain, with a 2024 adolescent birth rate of 4.85 (WHO, 2024).

Table 2. United States mandatory sexual health education requirements in different states.

Policy	National	Colorado	Texas	California	Arizona
2022 Teen Birth Rate (per 1,000 teen females)	13.6	11.1	20.4	9.8	15.1
Mandatory Sex Education	No	Yes	No	Yes	No
Mandatory HIV Education	No	Yes	Yes	Yes	No
Education must be medically accurate	No	Yes	Yes	Yes	Yes

Notes: Compiled by the author using data from the Centers for Disease Control and Prevention (2022, 2024) and the National Conference of State Legislatures (2020).

Only 30 out of 50 states require public schools to include a sexual health education curriculum (NCSL, 2020). As seen in Table 2, the SRH education mandated in each state varies widely, and leads to gaps in education for certain parts of the country. For progressive states such as Colorado and California, both sex education and HIV education are mandated in public schools, and the information is required to be medically accurate. As a student in Denver Public Schools, my classmates and I received a comprehensive SRH education starting in 4th grade. At a young age, we learned medically accurate information about menstruation, conception, and pregnancy. In high school, the SRH curriculum included contraception, STIs, sexuality, gender, and health relationships. In conservative states such as Arizona, sex education and HIV education are not mandated in public schools. This data shows that there is a wide disparity between different states in terms of the SRH education provided to adolescents throughout the country. This education gap affects SRH outcomes such as teen birth rates. According to Table 2, states with mandated SRH education, such as Colorado and California, have significantly lower teen birth rates as compared to states where little to no comprehensive SRH education is mandated, such as Texas and Arizona.

According to Figure 1, “Education” is mentioned in the ACA almost equally in frequency to that of the Spanish and South African policy documents. At 0.41 times per page, the word “Education” is used in regard to SRH health in instances such as “‘...education program’ means a program that is designed to educate adolescents on— ‘(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS’” (ACA, 2010). The prevalence of the word “Education” in the ACA indicates that United States policy highlights the importance of education. However, this contradicts the data in Table 2 which shows that some states neglect to include SRH educational requirements. There are clearly major gaps between the educational standards of different states.

It is widely understood that SRH education has a significant impact on SRH outcomes. As seen in Figure 1, the word “Education” is used 0.28 times per page in the Spanish SRH national policy. This document claims that a comprehensive SRH education is one of the objectives for sexual health set forth by the Spanish government. Additionally, this policy addresses SRH education focusing specifically on vulnerable populations such as LGBTQ+ individuals, or those who have experienced sexual assault (Estrategia Nacional de Salud Sexual y Reproductiva, 2011). Along with addressing a variety of SRH topics, the Spanish SRH policy

discusses a holistic view of SRH, like the SRHE framework discussed in the background section, including the importance of identity in SRH.

One of the more concerning negative SRH outcomes in South Africa is the high HIV rate. One study, investigating the necessity of SRH education in the prevention of HIV, claims “HIV positive children in early adolescence are poorly informed about sexual and reproductive health matters... service providers do not feel confident to inform and educate young adolescents and lack the resources to guide and assist them” (Vujovic et al., 2014). For this reason, South Africa has made education a priority, as seen in Figure 1 where the word “Education” is used 0.5 times per page. This is a higher frequency than is seen in the policy documents of the United States and Spain. The South African SRH policy document states, “Education has a strong positive link with contraceptive and sexual and reproductive health and rights service use, improved employment opportunities, and economic independence. Higher levels of education, comprehensive sexual education, and retaining learners in school are also associated with lower levels of teenage pregnancy, HIV, and other STIs” (National Integrated Sexual & Reproductive Health and Rights Policy, 2019). In South Africa, one of the main focuses of national SRH efforts is to further SRH education as a form of preventative medicine.

DISCUSSION AND CONCLUSION

Through comparison of the national policies on sexual and reproductive healthcare of Spain and South Africa, it appears as though the two main factors contributing to the negative SRH outcomes of the United States are insurance barriers and inconsistent sexual health education across the country. These results can partially be explained by the decentralization of the United States as compared to Spain and South Africa, as policies and programs in the US are often negotiated at the state level. While high-income individuals with health insurance frequently access SRH resources, low-income individuals with little to no health insurance receive limited care. While liberal states offer comprehensive SRH education to their public school students, students in conservative states receive none of the same education. These inconsistencies, in a country as large as the United States, create gaps between the SRH outcomes of different socio-economic groups, and drive down the national averages.

As seen in Figure 1, national SRH policy in the United States focuses heavily on health insurance issues such as the cost of care and uninsured populations. Current federal and state SRH policies focus more on how to assist people in overcoming insurance barriers, rather than expanding current resources and improving patient wellbeing. In a developed nation with a universal healthcare system, such as Spain, the SRH policy has no need to discuss healthcare costs, and focuses entirely on SRH issues, including health equity and patient wellbeing. In South Africa, the government has chosen to prioritize the improvement of SRH outcomes, providing universal healthcare and enacting policies aimed at improving SRH education and resource availability. If the United States hopes to achieve improved national SRH outcomes, it must universally improve both access to SRH resources and education, closing the gaps between populations across the country.

A method that has proven to mitigate health insurance barriers is the use of telemedicine in sexual and reproductive healthcare. One study found that the use of telemedicine improved SRH outcomes such as breastfeeding, the continuation of oral contraception, and early access to abortion services (DeNicola et al., 2020). Additionally, telehealth services are less costly than in-person services, which reduces healthcare costs for both the health insurance provider and the patient. Overall, women seeking SRH resources could experience lower copays, more timely medical attention, and improved health outcomes.

Next, it is critical that the United States federal government passes legislation to mandate SRH education within public schools across the country. In addition to including medically accurate sexual health and HIV curriculum, this education should include information regarding how students can access the SRH resources available to them. While the United States government has recognized the benefit of SRH education, it has not yet instituted a national requirement for the education of adolescents regarding their own health. Each of the three policy documents analyzed in Figure 1 acknowledged the importance of SRH education in the improvement of health outcomes, and the United States will need to expand the current education requirement if outcomes are to improve drastically.

Additionally, if the United States were to expand subsidized access to SRH resources, available to individuals with little to no health insurance, health outcomes would be significantly improved. Preventative medicine, including education, contraception, and birth control, are often less expensive than the treatment of STIs or the termination of a pregnancy. If healthcare

providers and insurance companies were to invest more heavily in preventative SRH resources, they would see a decrease in patient spending long-term. “Reported teenage pregnancy rates are generally lower for countries where parental consent for abortion is not required, youth SRH services are available in all areas and contraceptives are subsidized for all minors, compared with countries where these conditions are not met” (Part et al., 2013). The South African government has applied these measures, to improve SRH outcomes, as discussed in the background section (Strode & Essack, 2017). The organization Planned Parenthood has already implemented a similar strategy, providing affordable sexual and reproductive healthcare services across the country. The Planned Parenthood website claims that “most health insurance plans must cover 100% of the costs of preventive care — like birth control, STD testing, cancer screenings, and wellness visits” (Planned Parenthood, 2022). While abortion services are often available at Planned Parenthood centers, the organization recognizes the importance of preventative health measures in negating the need for abortion services in the first place.

In addition, if an effort were made to educate communities about the increased availability of resources, they would be more frequently utilized. As a high school student in the Denver Public Schools district, I had subsidized access to a variety of SRH resources. A Denver Health clinic, located in the basement of my high school, offered free contraception, STI testing, pregnancy testing, and counseling to any student who obtained parental consent. Throughout the mandatory sexual health education curriculum, available resources were frequently discussed. In the end, these resources were widely utilized by students at my high school who felt satisfied with their autonomy and the care that they received.

Finally, implementation of the SRHW and SRHE frameworks, discussed in the background section, would improve the sexual and reproductive healthcare offered to women in the United States. In terms of the sexual and reproductive health wellbeing framework, the focus would shift towards achieving the SRH goals that women set for themselves. With the sexual and reproductive health equity framework, the importance of intersectional identities would be stressed to close the gaps in SRH outcomes between diverse populations (Hart et al., 2022). If these two frameworks were implemented in sexual and reproductive healthcare within each state, patients would feel increasingly more satisfied with their overall healthcare experience, despite the costs. In addition, the national SRH outcomes would improve significantly.

The accuracy of this research may have been limited because a singular SRH policy document could not be identified for the United States, and the ACA was used as a proxy. While the ACA discusses SRH topics, it focuses mainly on expanding insurance coverage to American citizens. This difference in topic may have influenced the data seen in Figure 1. Further research should explore the gaps in SRH outcomes between various socio-economic and minority groups in the United States to identify strategies to strategically improve health outcomes in these smaller populations. The analysis of intersectional identities in the research of health outcomes is important to the future of healthcare research, and the improvement of healthcare systems.

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