Sexual and reproductive health services in universal health coverage (UHC): a review of recent evidence

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Objectives and methodology

Objective

• To explore the current situation vis-à-vis universal coverage of SRH services, and the extent to which SRH services have been prioritised in national UHC plans and processes.

Methodology

• Not a systematic review, because of the complex nature of the topic being explored
• Included publications in English; period: 2010 – 2019
• Wide range of sources beyond journal articles
• Covering one or more sexual and reproductive health services and one or more dimensions of Universal Health Coverage
• 253 articles included
The need to prioritise SRH services in UHC

• SRH services and UHC are interdependent and mutually reinforcing. Progress towards UHC depends on prioritising SRHR

• The lack of adequate attention to SRHR has led to a large unmet need for SRH services, jeopardising achievement of UHC

• SRHR and SRH services have some unique features which may pose challenges in the path to UHC unless special attention is paid to addressing these.

• And yet, SRH services have not always been on the agenda when global, and national-level discussions and decisions related to UHC are made, on financing health care, allocating resources and setting priorities (Kowalski 2015; Sen and Govender 2018; Fried et al. 2013; Adewole and Gavira 2018).
Weak evidence base on SRH and UHC

• The vast body of work on UHC rarely touches on SRH, while the SRH literature does not go beyond making the case for SRH.

• Very few studies on what was happening in different countries, and globally, to ensure that various UHC reforms (e.g. financing, priority-setting; engaging with private sector-providers) were aligned to the goal of universal access to services.

• Literature is fragmented:
  • Across specific components of SRH services (e.g. maternal health and family planning); and
  • Specific dimensions of UHC (e.g. financing and service delivery). Most did not examine the implications for UHC.
Limited inclusion of SRH services in ‘essential packages of health services’ (EPHS).

• EPHS: An attempt by governments with limited resources to make available at least an essential package of high-priority services free of charges or at low charges at the point of service-delivery.

• Limited range of services included. Those included may not be comprehensive: e.g., reproductive cancers could mean only screening.

• Inclusion may not be backed by adequate financial allocation, and so availability could be constrained and financial barriers (e.g. user fees, co-payments) may remain a barrier to access.
EPHS— who is involved and how decided?

- Process of developing EPHS usually top-down, involving the government, international donors, and national and international technical experts.
- Criteria for inclusion of services often not transparent
- Cost-effectiveness is the most widely used criterion.
- Community or CSO involvement in about a third of the (16) countries, but not much is known about how this influenced the process.
- One study found that SRH actors were not involved in the EPHS process because SRH was mostly international donor-funded. Resulted in the inclusion of only a small number of SRH services in the EPHS.
Financing SRH services – The overall picture

- SRH services in LMICs financed mainly by out-of-pocket expenditure by households (OOPE), leading to catastrophic health expenditure.
- International funding limited, dominated by US, and volatile. New forms of ‘blended’ funding (Global Financing Facility) coming into existence, but raise many concerns.
- Focus predominantly on HIV/AIDS (65% of funding), MCH (23%) and FP (9%).
Service-delivery challenges predominantly affecting SRH services

• Many of the services are preventive and promotive, needed by a large number of healthy persons

• Perhaps the only area in health where life-saving services are denied by legal and policy barriers; routine violation of human rights not protected by law; barriers to services because of criminalisation of sex-work, same-sex sexual relationships, lack of legal status (transgender persons, migrant workers)

• Restrictive gender-norms and gender inequalities in households and communities, and gender-biases within the healthcare system affect demand for services. Gender-blind policies and programme planning limit access to care.

• There has been a major trend towards engaging the private sector in SRH service delivery (contracting, voucher schemes, social franchises) over the past few decades. Available evidence shows that while there are instances of increased service utilisation, they do not increase the range of services available, expand availability in under-served areas or benefit economically weaker sections.
Accountability mechanisms for SRHR

• Internationally, human rights treaty bodies and Human Rights Council have played an important role. Several international networks have used tracking progress as an accountability mechanism: Countdown 2015, FP 2020, Information and Accountability for Women’s and Children’s Health, Voluntary Reporting on SDGs.

• At the national and subnational levels - more known about social accountability and to a lesser extent, legal accountability. The picture emerging is one of multiple actors and initiatives, acting at different levels, not co-ordinated across various levels (e.g. international to national), or horizontally across various initiatives.

• No examples of social accountability initiatives for advancing SRH in UHC
Emerging action-agenda for advancing SRH in UHC

- **Make the case** for a comprehensive range of SRH services in EPHS; and for the participation of diverse SRHR actors in country priority setting processes for its development; representation of voices of the most marginalised groups.

- **Prioritise** reduction of out-of-pocket expenditure and Catastrophic health expenditure for SRH services.

- **Advocate** for increased international public-funding that are stable and sustained, for a comprehensive range of SRH services.

- **Work towards improved** coordination and innovative strategising among like-minded actors implementing accountability initiatives to be more effective.

- **Challenge** legal and policy barriers to accessing SRH services and act against gender-biases in the health system

- **Prioritise evidence-building:** We need to distill practice-based knowledge on how to make change happen towards universal access to SRH services
The pandemic has cast the spotlight on the consequences of the lack of universal coverage of SRH services

We see all the challenges highlighted in this review converge, to deprive access to SRH services

Exacerbates existing gender, economic and social inequalities in access to SRH services: especially challenging for the most contested services, such as safe abortion, and for marginalised populations who are already dealing with legal, economic, social, cultural and logistical barriers to care.

Also provides an opportunity to make some radical changes to enable access, e.g. as outlined in the recent WHO guidelines to national governments enable access to essential services.