ARASA TRAINING AND LEADERSHIP PROGRAMME, MODULE 3

UNIVERSAL HEALTH COVERAGE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

EVERY BODY COUNTS

ARASA AIDS & Rights Alliance for Southern Africa

LEARNERS GUIDE

Contents

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Unit outcomes

At the end of this unit, you should be able to:

- Understand and describe universal health coverage
- Understand and articulate the linkage between universal health coverage and sexual and reproductive health and rights
- Describe how universal health coverage is central to the realisation of sexual and reproductive health and rights and vice versa.
- Develop an advocacy plan for universal access to SRHR within universal health coverage in your country.

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What is Universal Health Coverage (UHC)?

UHC is a global goal that all member states of the UN have committed to achieve by 2030 to as part of the Sustainable Development Goals (SDGs). In 2019, this commitment was further strengthened with the Political Declaration of the High-Level Meeting on Universal Health Coverage setting out an ambitious agenda for the next 10 years.

SDG 3.8. Universal health coverage

Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines for all.

UHC means that all individuals and communities receive the health services they need, including the full range of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care, without suffering financial hardship.

With UHC everybody should have access to quality services that address the most significant causes of disease and death, which are good enough to improve the health of the people who receive them

By protecting people from the financial consequences of paying for health services out of their own pockets UHC reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow money, which in turn destroys their futures and often those of their children.

Key facts

At least half of the world's population still do not have full coverage of essential health services.

About 100 million people are still being pushed into extreme poverty (defined as living on 1.90 USD or less a day) because they have to pay for health care.

Over 930 million people (around 12% of the world's population) spend at least 10% of their household budgets to pay for health care.

All UN Member States have agreed to try to achieve universal health coverage (UHC) by 2030, as part of the Sustainable Development Goals.

Source: WHO https://www.who.int/news/item/13-12-2017-world-bank-and-who-half-the-world-lacks-access-to-essential-health-services-100-million-still-pushed-into-extreme-poverty-because-of-health-expenses.

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What UHC is not

There are many things that are not included in the scope of UHC:

- UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis.
- UHC is not just about health financing. It encompasses all components of the health system: health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation.
- UHC is not only about ensuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available.
- UHC is not only about individual treatment services, but also includes population-based services such as public health campaigns, adding fluoride to water, controlling mosquito breeding grounds, and so on.
- UHC is comprised of much more than just health; taking steps towards UHC means steps towards equity, development priorities, and social inclusion and cohesion.

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How can countries make progress towards UHC?

Many countries are already making progress towards UHC. All countries can take actions to move more rapidly towards it, or to maintain the gains they have already made. In countries where health services have traditionally been accessible and affordable, governments are finding it increasingly difficult to respond to the ever-growing health needs of the populations and the increasing costs of health services.

Moving towards UHC requires strengthening health systems in all countries. Robust financing structures are key. When people have to pay most of the cost for health services out of their own pockets, the poor are often unable to obtain many of the services they need, and even the rich may be exposed to financial hardship in the event of severe or long-term illness. Pooling funds from compulsory funding sources (such as mandatory insurance contributions) can spread the financial risks of illness across a population. Increasing domestic resources for health is critical.

Improving health service coverage and health outcomes depends on the availability, accessibility, and capacity of health workers to deliver quality people-centred integrated care. Investments in quality primary health care will be the cornerstone for achieving UHC around the world. Investing in the primary health care workforce is the most cost-effective way to ensure access to essential health care will improve. Good governance, sound systems of procurement and supply of medicines and health technologies and well-functioning health information systems are other critical elements.

See: https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

1. *https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf*

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Government commitments on UHC[1]

We, Heads of State and Government and representatives of States and Governments, assembled at the United Nations on 23 September 2019, with a dedicated focus for the first time on universal health coverage, reaffirm that health is a precondition for and an outcome and indicator of the social, economic and environmental dimensions of sustainable development and the implementation of the 2030 Agenda for Sustainable Development, and strongly recommit to achieve universal health coverage by 2030, with a view to scaling up the global effort to build a healthier world for all, and in this regard we:

9. Recognize that universal health coverage implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative and palliative essential health services, and essential, safe, affordable, effective and quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population;
14. Recognize the fundamental importance of equity, social justice and social protection mechanisms as well as the elimination of the root causes of discrimination and stigma in health-care settings to ensure universal and equitable access to quality health services without financial hardship for all people, particularly for those who are vulnerable or in vulnerable situations;

We therefore commit to scale up our efforts and further implement the following actions:

32. Strengthen efforts to address communicable diseases, including HIV/AIDS, Tuberculosis, malaria and hepatitis, as part of universal health coverage and to ensure that the fragile gains are sustained and expanded by advancing comprehensive approaches and integrated service delivery and ensuring that no one is left behind;
54. Engage all relevant stakeholders, including civil society, the private sector and academia, as appropriate, through the establishment of participatory and transparent multi-stakeholder platforms and partnerships, to provide input to the development, implementation and evaluation of health- and social-related policies and reviewing progress for the achievement of national objectives for universal health coverage, while giving due regard to addressing and managing conflicts of interest and undue influence;
68. Ensure, by 2030, universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes, which is fundamental to the achievement of universal health coverage, while reaffirming the commitments to ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences;
69. Mainstream a gender perspective on a systems-wide basis when designing, implementing and monitoring health policies, taking into account the specific needs of all women and girls, with a view to achieving gender equality and the empowerment of women in health policies and health systems delivery and the realization of their human rights, consistent with national legislations and in conformity with universally recognized international human rights, acknowledging that the human rights of women include their right to have control over and decide freely and responsibly on all matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence;
70. Ensure that no one is left behind, with an endeavour to reach the furthest behind first, founded on the dignity of the human person and reflecting the principles of equality and non-discrimination, as well as to empower those who are vulnerable or in vulnerable situations and address their physical and mental health needs which are reflected in the 2030 Agenda for Sustainable Development, including all children, youth, persons with disabilities, people living with HIV/AIDS, older persons, indigenous peoples, refugees and internally displaced persons and migrants.

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African UHC frameworks and commitments[2]

n addition to the UN Political Declaration and the World Health Assembly resolution from 2019 that all African countries have endorsed, there are a number of important regional-level commitments and policy instruments that are useful for UHC-related advocacy. [PITCH Advocacy Toolkit)

Abuja Declaration (2001)	African Union (AU) countries pledged to set a goal of allocating at least 15% of their annual budget to the health sector. Very few countries have met this target. The Abuja +12 Declaration in 2013 saw governments renew their pledges to end the epidemics of HIV, TB and malaria by 2030.
Universal Health Coverage in Africa: From Concept to Action (2016)	This call to action sets out five key areas for African states linking health to economic growth: financing, services, equity, preparedness and governance.
African Health Strategy 2016-2030	A strategic framework to strengthen health systems performance, increase investments in health, improve equity and address social determinants of health to reduce priority diseases burden by 2030.
African Union Catalytic Framework to end AIDS, TB and Malaria in Africa by 2030	A strategic framework setting out targets and milestones endorsed by the AU in 2016. A set of objectives are linked to each disease, with targets to be achieved if the diseases are to be eliminated by 2030. These objectives all have a set of interim targets (or 'milestones') to be met by 2020.
67th WHO Regional Committee for Africa (2017)	African Health Ministers agreed to implement six comprehensive framework actions in their countries that will contribute fundamentally to attainment of UHC.
African Scorecard on Domestic Financing for Health 2019	An annually updated health financing tool for AU member states to use in financial planning and expenditure tracking.

Key Targets, Commitments and Actions in the Political Declaration on UHC[3]

- **Ensure political leadership beyond health:** Commit to achieve UHC for healthy lives and well- being for all at all stages, as a social contract
- **Leave no one behind:** Pursue equity in access to quality health services with financial protection.
- **Legislate and regulate:** Create a strong, enabling regulatory and legal environment responsive to people's needs.
- **Uphold quality of care:** Build quality health systems that people and communities trust.
- **Invest more, invest better:** Sustain public financing and harmonize health investments
- **Move together:** Establish multi-stakeholder mechanisms for engaging the whole of society for a healthier world.

2. *PITCH: Protect the gains, push for progress: How to advocate for HIV services in universal health coverage, in the context of COVID-19, 2020, https://www.arasa.info/media/arasa/Resources/pitch-uhc-advocacy-guide-2020-final.pdf*
3. *Uhc2039, State of commitment to UHC: Synthesis, 2020*

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UHC: founded on the right to health and health equity

The concept of UHC goes right back to the WHO Constitution of 1948 declaring health a fundamental human right. The human right to health is recognized in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights affirms: "Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services". The International Covenant on Economic, Social and Cultural Rights provides the most comprehensive article on the right to health in international human rights law. In accordance with article 12.1 of the Covenant, States parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", while article 12.2 enumerates, by way of illustration, a number of "steps to be taken by the States parties... to achieve the full realization of this right". Additionally, the right to health is recognized, inter alia, in article 5 (e) (iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965, in articles 11.1 (f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and in article 24 of the Convention on the Rights of the Child of 1989. The right to health is also recognised in the African Charter on Human and Peoples' Rights of 1981 (art. 16).

The right to health is closely related to and dependent upon the realization of other human rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health.

The right to health is more than access to timely and appropriate health care and cannot be realised without also addressing the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

For the right to health to be realised health facilities, goods and services must meet the following criteria:

- **Availability:** Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity.
- **Accessibility:** Health facilities, goods and services have to be accessible to everyone without discrimination. Accessibility has four overlapping dimensions:
- **Non-discrimination:** health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination;
- **Physical accessibility:** health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;
- **Economic accessibility (affordability):** health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households;

- **Information accessibility:** accessibility includes the right to seek, receive and impart information and ideas concerning health issues.
- **Acceptability:** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
- **Quality:** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. [4]

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Why do we need UHC?

In 2017, less than half of the global population was covered by essential health services.[4] Even in wealthy countries, the national health system provided by the state only covers part of the population, a limited range of services and only part of the total cost. Each year, an estimated 100 million people are pushed into extreme poverty because of health expenses.

Three dimensions of UHC

To achieve UHC, countries have to advance all three dimensions:

1. increase the number of people who are covered;
2. extend the range of services that are included; and
3. reduce 'out of pocket' charges and fees for health services.

Leave no one behind, with specific attention to the poor, vulnerable and marginalised

Ensure progressive access to a wide range of high-quality services

Eliminate financial hardship among users of health care services

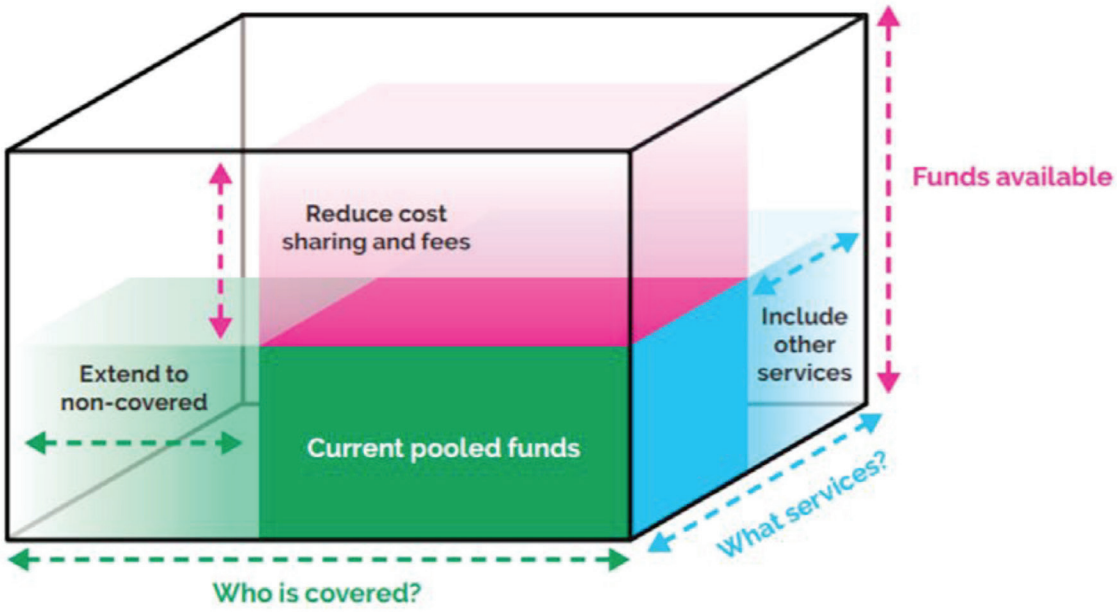
4. General comment 14 Committee on Economic, Social and Cultural Rights. General Comment No. 14: the right to the highest attainable standard of health. UN Doc. E/C.12/2000/4; 2000 http://www1.umn.edu/humanrts/gencomm/escgencom14.htm

In order to do this Governments need not only to increase domestic funding for health but also to make critical choices around who to include first, which services to expand and how to move towards a system that shares the financial risk equally across society. Countries that have been able to make most progress towards UHC have prioritised spending on health from general taxation, rather than private or voluntary health insurance schemes. The 2019 UHC Global Monitoring Report found that while health coverage globally has been improving, financial protection has not and in many countries gains in service coverage have come at a major cost to individuals and their families.

The three dimensions of UHC are often represented as the UHC cube (see below). It conceptualises the journey ***towards*** UHC as a task of making progress along expanding each of the dimensions towards 100% to help 'fill' the cube.

The three dimensions to cover when moving towards universal coverage

Source: WHO Universal Coverage – Three Dimension



Source: PITCH: Protect the gains, push for progress: How to advocate for HIV services in universal health coverage, in the context of COVID-19, 2020, https://www.arasa.info/media/arasa/Resources/pitch-uhc-advocacy-guide-2020-final.pdf

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Universal Coverage and SRHR

The Sustainable Development Goals (SDGs) explicitly recognize sexual and reproductive health as essential to health, development and women's empowerment. Sexual and reproductive health is referenced under both SDG 3, including met family planning needs, maternal health-care access and fertility rates in adolescence, and SDG 5 (gender equality), which additionally refers to sexual health and reproductive rights. With the SDGs, the world has also committed to achieving UHC, including financial risk protection, access to high-quality essential health-care services and access to safe, effective, high-quality and affordable essential medicines and vaccines for all. The 2019 Political Declaration on UHC adopted by the United Nations General Assembly re-emphasizes the right to health for all and a commitment to achieving universal access to sexual and reproductive health services and reproductive rights as stated in the SDGs. UHC and SRHR are thus inextricably linked. Without taking into account a population's SRHR needs, UHC is impossible to achieve, as many of the basic health needs are linked to people's sexual and reproductive health. Similarly, universal access to SRHR cannot be achieved without countries defining a pathway towards UHC, which includes prioritizing resources according to health needs.

For countries to realize the targets of UHC and universal access to SRHR, adopting a comprehensive definition of and approach to SRHR is essential. SRHR are essential to human life and to overall health and well-being over the life course and, therefore, SRHR should be part of public health and development strategies. Investing in SRHR is beneficial to societies because it strengthens families and helps increase prosperity. The most vulnerable and poorest people, with the least access to health care, bear a disproportionate burden of poor sexual and reproductive health. Consequently, a comprehensive approach to SRHR is needed to address gaps in the delivery of SRHR interventions and the political, social, cultural, gender, economic and financial barriers that prevent people from fully achieving their SRHR.

The comprehensive definition of SRHR proposed by the Guttmacher–Lancet Commission[5] covers sexual health, sexual rights, reproductive health and reproductive rights and reflects an emerging consensus on the services and interventions needed to address the sexual and reproductive health needs of all individuals. Additionally, it addresses issues such as violence, stigma and respect for bodily autonomy, which profoundly affect individuals' psychological, emotional and social well-being. It further specifically addresses the SRHR of neglected groups (e.g. adolescent girls, LGBTI individuals and those with disabilities). As such, the definition offers a comprehensive framework to guide governments, United Nations agencies, civil society and other stakeholders involved in designing policies, services and programmes that address all aspects of SRHR effectively and equitably.

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Integrated definition of Sexual and Reproductive Health and Rights[6]

Sexual and reproductive health is a state of physical, emotional, mental and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in the promotion of self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right.

Achievement of sexual and reproductive health relies on the realization of sexual and reproductive rights, which are based on the human rights of all individuals to:

- have their bodily integrity, privacy and personal autonomy respected;
- freely define their own sexuality, including sexual orientation and gender identity and expression;
- decide whether and when to be sexually active;
- choose their sexual partners;
- have safe and pleasurable sexual experiences;
- decide whether, when and who to marry;
- decide whether, when and by what means to have a child or children, and how many children to have;
- have access over their lifetime to the information, resources, services and support necessary to achieve all of the above, free from discrimination, coercion, exploitation and violence.

5. Starrs, Ann, and others (2018). Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. Lancet, vol. 391
6. ibid

Essential sexual and reproductive health services must meet public health and human rights standards, including the "availability, accessibility, acceptability and quality" framework of the right to health.

The services should include:

- accurate information and counselling on sexual and reproductive health, including evidence-based CSE;
- information, counselling and care related to sexual function and satisfaction;
- the prevention, detection and management of sexual and gender-based violence and coercion;
- a choice of safe and effective contraceptive methods;
- safe and effective antenatal, childbirth and postnatal care;
- safe and effective abortion services and care;
- the prevention, management and treatment of infertility;
- the prevention, detection and treatment of STIs, including HIV infection, and of reproductive tract infections;
- and the prevention, detection and treatment of reproductive cancers.

A comprehensive definition of sexual and reproductive health and rights

Source: UNFPA, 2019

Proposed essential SRHR interventions as part of a comprehensive approach to SRHR

- Comprehensive sexuality education (in and out of school);
- Counselling and services for a range of modern contraceptives, with a defined minimum number of types of methods;
- Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care;
- Comprehensive abortion care including safe abortion care to the full extent of the law and post-abortion care in all settings;
- Prevention and treatment of HIV infection and other STIs;
- Prevention of, detection of, immediate services for and referrals for cases of sexual and gender-based violence;
- Prevention, detection and management of reproductive cancers, especially cervical cancer;
- Information, counselling and services for subfertility and infertility;
- Information, counselling and services for sexual health and well-being

The cross-cutting principles of equity in access, quality of care and accountability, are key to ensuring a comprehensive approach to SRHR and should be part and parcel of implementing the essential SRHR interventions as part of UHC. These principles impact both the delivery of sexual and reproductive health services and the realization of individuals' sexual and reproductive rights:

- **Equity in access** – Individuals in need of services can access them irrespective of their ability to pay, socioeconomic status, geographic location, ethnicity, education or gender and are empowered to use these services;
- **Quality of care** – Commodities and facilities are of good quality and services are delivered in a safe, effective, timely, efficient, integrated, equitable and people-centred manner, based on care standards and treatment guidelines and taking into account people's experiences and perceptions of care, including affordability and acceptability;
- **Accountability** – SRHR is underpinned by human rights and political, financial and performance accountability, with inclusiveness and transparency at all levels of the health system, and ensuring that rights holders' views and demands are captured and taken into account in planning and implementation.[7]

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Progress on UHC?

Progress on moving towards realising UHC, and in particular in the area of SRHR services varies. Access coverage shows the unacceptable inequity across regions, between high income and low income countries and even within countries. Even in high income countries UHC is often inadequate and does not cover comprehensive sexual and reproductive health services to fulfil sexual and reproductive health and rights.

Following the commitments agreed to at the United Nations Sustainable Development Summit in 2015, which included attaining UH by 2030, most countries have pursued change. About 75 countries have enacted UHC legislation. Since 2015, many countries – including Kenya, India, Indonesia and South Africa – have developed policy frameworks and committed new resources to expanding health services.

Despite all this movement, progress needs to be accelerated. On current trends, UHC will not be achieved by 2030, leaving poor people and poor countries behind. The pervasive inequity in financial burdens and limited financial protection among the poor, vulnerable and marginalized population is not acceptable.

Coverage of sexual and reproductive health services	The health service package offered in many developing countries as part of UHC only addresses a limited number of sexual and reproductive health services and is not sensitive to the diverse needs of population groups, such as young people and vulnerable and marginalized women and girls.
Provision of contraception	Worldwide, an estimated 214 million women who want to delay or avoid pregnancy are not using a modern method of contraception. Globally, between 1990 and 2015, the birth rate among adolescent girls aged 15–19 declined only slightly, from 59 births to 51 births per 1,000 girls. Unintended pregnancy among these groups leads to an elevated risk of subsequent school dropout and maternal mortality. The poor, the less educated, and women living in rural areas have a persistently higher unmet need for family planning than the least poor and more educated and those living in urban areas.
Safe abortion care	WHO estimates that each year 55.7 million abortions occur worldwide, of which 45% are unsafe. Ninety seven per cent of the unsafe abortions globally occur in developing countries. There is stark inequity in the proportion of unsafe abortion between developing and developed countries. In developing countries, it is estimated that 49.5% of all abortions are unsafe, whereas in developed countries, this proportion is 12.5%.

7. UNFPA, Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage Background Document for The Nairobi Summit on ICPD25 – Accelerating The Promise, 2019

Gynaecology including cervical cancer screening	In 2012, 230,000 women in developing countries and 36,000 women in more developed countries died from cervical cancer. The difference in the burden of disease can be explained by the fact that coverage of cervical cancer screening in developing countries, where 83% of cervical cancer deaths worldwide occur, is on average 19%, compared to 63% in developed countries
Prenatal and post natal care	Progress in increasing access to antenatal care has been slow over the past 25 years. Only 52% of pregnant women received the recommended minimum of four visits in 2015. The disparity in post natal care is prominent: a review on post natal care in LMICs showed that women with higher socioeconomic status, higher education and those living in urban areas were more likely to use post natal care.
Screening and referral for gender based violence	It is estimated that more than one in three (35%) women worldwide have experienced either physical and/or sexual intimate partner violence or non partner sexual violence in their lifetime. Moreover, the risk of violence is higher for people with disabilities, refugees and women in conflict settings. Despite the high prevalence and serious consequences of sexual and gender based violence, access to health services for survivors is far from universal. Due to stigma, shame and lack of or poor services, many women do not report violence or seek care. The Global status report on violence prevention 2014 found that only half of 133 countries studied reported having violence related services in place to protect and support survivors of violence. The services are often fragmented and not integrated into the health system, leading to women having to navigate different services, pay large costs and experience long waits.
Insufficient financial commitments for sexual and reproductive health services and goods	A substantial proportion of spending on sexual and reproductive health services is currently paid by individuals due to a lack of financial protection and insufficient government and donor funding. For instance, contraceptive commodities are not covered by national insurance in many countries. In 2014, more than US$1.2 billion was spent on contraceptive supplies across 135 LMICs. The share of individuals who paid for their own contraceptive supplies was 58%, while all donor funding and domestic government expenditure on supplies were at 25% and 17% respectively. Donor funding for sexual and reproductive health, especially sexual health, has fluctuated and cannot be expected to grow significantly beyond current levels. This means that an increased focus on mobilizing domestic resources in support of sexual and reproductive health services is essential.
Limited financial protection for sexual and reproductive health services	Several governments have introduced financing mechanisms to alleviate poverty that results from seeking reproductive maternal health care. Mechanisms such as cash transfers, voucher systems and user fee waivers have generally increased the uptake of health services. However, the key to protecting people from financial hardship is to ensure that most funds for a health system are prepaid through some type of insurance scheme or tax, and that services are purchased from these pooled funds in a way that limits the need for out of pocket payments. Although national, social, community based or public health insurance schemes or tax funded health services as steps to UHC exist in many developing countries, the populations that are covered by such schemes are limited. People working in the informal sector and the most vulnerable and marginalized, such as young people and refugees, are left behind. A study in Ghana has shown that even when insurance is available to women in the poorest income group, they were less likely to seek antenatal care than women from other income groups. Even when a financial protection scheme exists, the services covered by these schemes often do not include comprehensive sexual health coverage and sexual and reproductive health and rights health services. A study of 20 LMICs in 2012–2015 found that no country studied had a community based health insurance scheme with more than 100 members that had contraception included in the package. Contraception is often left out while financial protection schemes often cover maternal and child healthcare services.

High out of pocket expenditure on reproductive health services	Substantial inequity in out of pocket expenditure also exists within countries. In Kenya 38% of total expenditure on sexual and reproductive health services derived from out of pocket expenditure. Among the total household out of pocket expenditure on general health services, families in Kenya spent 14% on sexual and reproductive health services. In Democratic Republic of Congo households bear 68% of total expenditure on reproductive health, while the government contribution is only 0.2%. A study assessing household expenditure on sexual and reproductive health in India and Kenya found that there was a statistically significant difference in the proportions of spending on sexual and reproductive health services across income quintiles in both settings. In India, the poorest households spent two times, and in Kenya 10 times, more on seeking care than the least poor households. Women systematically made higher out of pocket payments than men, partly due to the high financial costs related to delivery care and other reproductive health services.

Source: IPPF, Leaving no one behind: UHC and SRHR: https://www.ippf.org/static/docs/Publication_-_Leaving_no_one_behind.pdf

Steps to be taken to achieve UHC at country level: from political commitment to action

Whilst governments may have demonstrated political commitment to UHC, which is inclusive of a comprehensive approach to SRHR, by signing on to the Political Declaration on UHC, it is critical that these political commitments are translated into actionable steps for implementation. These include the following:[8]

- analyse the SRHR needs of the population and interlinkages between essential
- SRHR interventions;
- map and mobilize all key stakeholders relevant for implementing the package
- of interventions;
- analyse supply- and demand-side requirements in implementing the essential
- SRHR package;
- prioritize interventions and develop a UHC benefits package based on the SRHR
- needs of the population;
- mobilize and coordinate funds to enable and effectively fund interventions;
- progressively realize the package of essential SRHR interventions as part of UHC.

The role of civil society and communities in achieving UHC[9]

We commit to engage all relevant stakeholders, including civil society, private sector and academia, as appropriate, through the establishment of participatory and transparent multi-stakeholder platforms and partnerships, to provide input to the development, implementation and evaluation of health- and social-related policies and reviewing progress for the achievement of national objectives for universal health coverage, while giving due regard to addressing and managing conflicts of interest and undue influence – UN Political Declaration on UHC, 2019

The Sustainable Development Goals (SDGs) and Universal Health Coverage (UHC) agendas provide important opportunities to reimagine and enhance equitable health coverage, which meets the needs and rights of all, and in particular of key and vulnerable populations. This enhanced health coverage builds upon existing progress made in both strengthening the evidence base and implementing bi-directional SRHR and HIV linkages, to ensure enabling policy environments, better aligned health systems and integrated service delivery.

Civil society and communities have a critical role to play in achieving UHC, especially in advocacy, research and service delivery. They need to be at the decision-making table at every stage of the design, implementation and monitoring of UHC, and hold governments to account, especially when it comes to the rights of the most marginalised people in society.

8. UNFPA, Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage
Background Document for The Nairobi Summit on ICPD25 – Accelerating The Promise, 2019
9. This section and the tools included are based on the advocacy tools contained in PITCH: Protect the gains, push for progress: How to advocate for HIV services in universal health coverage, in the context of COVID-19, 2020, https://www.arasa.info/media/arasa/Resources/pitch-uhc-advocacy-guide-2020-final.pdf as well as in the IMAP Statement on UHC and SRHR, October 2020, https://www.ippf.org/sites/default/files/2020-10/IMAP%20Statement%20on%20UHC%20%26%20SRHR%20English.pdf
And the WHO/UNFPA Call to Action to attain UHC through linked SRHR and HIV interventions, 2018, http://apps.who.int/iris/bitstream/handle/10665/273148/WHO-RHR-18.13-eng.pdf?ua=1

It may be helpful to think of your advocacy work on UHC in terms of four pillars:

1. The right to health as central to the design and delivery of UHC
2. Community-led health services as central to the design and delivery of UHC
3. The voice and leadership of communities as critical to the UHC process
4. The scaling up of public investment in health and public services to achieve the SDGs

Possible actions by CSOs and CBOs to move the UHC agenda forward

1. Situational analysis:

An important first step in planning your advocacy is to conduct an initial assessment of the current situation in your country regarding the SRH services and care provided at health facilities to ensure that service delivery is in accordance with the package of SRHR interventions proposed by the Guttmacher-Lancet commission. For instance, such assessments can involve determining the range of SRH services provided to identify services neglected in the SRH service delivery continuum; health care worker capacity and attitudes; availability of SRH commodities and supplies; and the extent to which SRHR services and available, accessible, acceptable and of high quality.

The findings of this assessment will enable you to plan what issues your advocacy will need to address.

2. Potential themes for advocacy:

Advocacy theme	Key action
Ensure meaningful community engagement in all aspects of research, design, implementation and monitoring of linked SRHR and HIV policies, financing mechanisms and service delivery.	CSOs should proactively engage with civil society and communities to build their capacity for meaningful and targeted participation in design, development, implementation and evaluation of approaches aimed at achieving universal access to SRHR within UHC and engage in advocacy for meaningful community engagement in UHC processes. Universal access to SRHR in UHC cannot be achieved without the involvement of those whose lives are most affected and without reliance being placed on social accountability mechanisms, community knowledge and lived experience.
Create an enabling environment for universal access to SRHR in UHC.	Advocate for legal reforms and policy changes in countries with harmful laws and policies to create an enabling environment that supports the fulfillment of the SRHR needs of all people to leave no one behind.
Ensure the inclusion of the essential SRHR interventions in national UHC plans and frameworks	Participate in national discussions about UHC and SRHR and advocate for the prioritization of the comprehensive package of essential SRHR interventions as part of UHC. In particular, it is important to demand the inclusion of interventions that may be considered particularly sensitive such as safe abortion, post abortion care and sexual wellbeing. Place and maintain pressure on parliamentarians and government leaders to honour government (financial) commitments towards UHC and universal access to SRHR, as well as gender equality and the empowerment of women, girls, the LGBTI community and vulnerable and marginalized populations.
Establish stronger multi-sectoral partnerships	Universal access to SRHR within UHC goes beyond the health sector and requires collaborative and cooperative efforts with a multitude of stakeholders in other sectors, for instance education, finance, youth or gender. Map existing national contexts, priorities, stakeholders and partnerships to identify where to improve alignment and establish common ground with other CSOs both within and outside health domains to mobilise a joint, multisectoral movement for universal access to SRHR within UHC.
Funding the provision of universal access to SRHR within UHC through domestic resources	Advocate for the reallocation of existing vertical health funding to cover comprehensive and integrated SRHR service delivery within UHC and for an increase in domestic health funding through, for example, public financing and national health insurance schemes.

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Useful additional readings and resources

- WHO Fact Sheet: Universal Health Coverage
  https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)

- Political Declaration on Universal Health Coverage
  https://www.un.org/pga/73/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf

- PITCH: Protect the gains, push for progress: How to advocate for HIV services in universal health coverage, in the context of COVID-19, 2020, https://www.arasa.info/media/arasa/Resources/pitch-uhc-advocacy-guide-2020-final.pdf

- Uhc2030, State of commitment to UHC: Synthesis, 2020
  https://www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/Key_Issues/State_of_UHC/SoUHCC_synthesis_2020_final_web.pdf

- Starrs, Ann, and others (2018). Accelerate progress – sexual and reproductive health and rights for all: report of the Guttmacher–Lancet Commission. Lancet, vol. 391 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30293-9/fulltext

- UNFPA, Sexual and Reproductive Health and Rights: An Essential Element of Universal Health Coverage, Background Document for The Nairobi Summit on ICPD25 – Accelerating The Promise, 2019
  https://www.unfpa.org/sites/default/files/pub-pdf/SRHR_an_essential_element_of_UHC_2020_online.pdf

- IPPF, Leaving no one behind: UHC and SRHR: https://www.ippf.org/static/docs/Publication_-_Leaving_no_one_behind.pdf

- IMAP Statement on UHC and SRHR, October 2020,
  https://www.ippf.org/sites/default/files/2020-10/IMAP%20Statement%20on%20UHC%20%26%20SRHR%20English.pdf

- WHO/UNFPA Call to Action to attain UHC through linked SRHR and HIV interventions, 2018,
  http://apps.who.int/iris/bitstream/handle/10665/273148/WHO-RHR-18.13-eng.pdf?ua=1

Videos:

- Strathmore Business School: UHC in Kenya https://www.youtube.com/watch?v=IPGZcJdfDpc&t=257s

- Universal Health Coverage Explained https://www.youtube.com/watch?v=FIETZ202Ovg