

IMAP Statement

on Universal Health Coverage and Sexual and Reproductive Health and Rights

This statement was prepared by the International Medical Advisory Panel (IMAP) and was approved in October 2020.

Background

The world has committed to achieving Universal Health Coverage (UHC) by 2030.¹ UHC means that *all individuals and communities receive the health services and care they need without suffering financial hardship*. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care², and comprises an explicit commitment to provide sexual and reproductive health (SRH) services for all.

UHC is deeply rooted in the right to health as set out in the 1948 Universal Declaration of Human Rights³, the World Health Organization (WHO) Constitution⁴, and the 1976 International Covenant on Economic, Social and Cultural Rights⁵. UHC lays a foundation for promoting and attaining the highest standard of health and well-being for all people, across all ages and social groups, without discrimination of any kind, and plays a pivotal role in countries' progress towards sustainable economic and socially equitable development.

As a leading advocate^a for universal access to essential SRH care, services and rights, IPPF believes that efforts towards achieving UHC must be anchored on principles of equity, equality,

social justice, and the right to health for all.

Sexual and reproductive health and rights (SRHR)^b are an essential element of UHC and an integral part of the right to health for all,⁶ as agreed in the UHC Political Declaration adopted in 2019.¹ To realize this right, every individual must be free to make their own choices about their bodies and SRH, without any forms of discrimination, stigma, violence or coercion. Quality SRH care, education and information should be available, accessible and affordable to all those in need, regardless of their age, relationship status, sexual orientation, gender identity, race, ethnicity, geographic location, socioeconomic and other status (e.g. legal, religious, political). Additionally, SRHR are essential to attaining individuals' overall health and well-being, and thus a vital driver to accelerate progress towards sustainable development.

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a See also the IPPF Advocacy Common Agenda (2019), available at: <https://www.ippf.org/resource/ippfs-advocacy-common-agenda>

b Note that sexual and reproductive health and rights are defined in this statement in line with the Guttmacher-Lancet Commission definition; cf. Starrs, AM, et al (2018) Accelerate progress-sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission. *Lancet*. 391(10140), pp. 2642–2692.

The 1994 International Conference on Population and Development (ICPD) marked a paradigm shift towards a people-centred approach and placed SRHR within a wider development framework. The ICPD Programme of Action (PoA) affirmed SRH as a fundamental human right and asserted that people's rights, choices and wellbeing should be at the heart of sustainable development.⁷ Since 1994, the world has made great progress in reducing SRH-related morbidities and mortality.^{c,8}

The Sustainable Development Goals (SDGs)⁹ recognize the importance of SRHR for improving health and achieving gender equality. In addition to the target of achieving UHC (target 3.8), Agenda 2030 also commits countries to reaching *universal access to sexual and reproductive healthcare services* (target 3.7) and *universal access to sexual and reproductive health and reproductive rights* (target 5.6).

Despite these improvements, progress has been uneven¹⁰ and large-scale initiatives to strengthen health systems have often neglected SRHR. As a result, delivery of, and access to, essential SRH services has proved elusive and inequitable, while the realization of the highest attainable standard of SRH and thus the right to health is still out of reach for far too many individuals. This is

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particularly the case in the poorest countries where persistently high rates of SRH-related ill health and associated mortality are now largely concentrated. For instance, global targets on reducing maternal mortality have not been achieved, 218 million women and girls in low and middle-income countries (LMICs) have unmet needs for contraception¹¹ and 25 million unsafe abortions occur each year. Over 350 million women and men need treatment for curable sexually transmitted infections (STIs) and the scale and impact of sexual and gender-based violence (SGBV) is staggering, affecting an estimated one-third of all women during their lives.⁸ The COVID-19 pandemic is not only negatively impacting delivery of SRH services, but further exacerbating challenges in continuing the provision of and securing access to a range of essential SRH services¹² as well as initiatives to prevent and combat SGBV¹³.

As evidenced by a growing body of research, poor health outcomes are strongly related to gender inequalities, discrimination, violence, and lack of SRHR information and services.¹⁴ The integration of SRHR in health interventions and programmes plays an important role in improving health and well-being for all.¹⁵ UHC provides the opportunity for this integration¹⁶, and universal access to SRHR cannot be achieved without countries defining a pathway towards UHC which includes prioritizing resources according to health needs, underpinned by the principles of health as a human right, leaving no one behind, gender equality, and inclusiveness and non-discrimination.¹⁷

The purpose of this statement

The purpose of this statement is to provide guidance for IPPF Member Associations (MAs) to inform and strengthen their advocacy efforts towards the integration and provision of essential SRH services within UHC national plans of action. The statement also reinforces IPPF's commitment to a rights-based approach to SRH service provision.

c The maternal mortality ratio decreased from 369 per 100,000 live births in 1994 to 211 in 2017. Adolescent birth rates have declined (from 65 to 44 births per 1,000 women between 1990–95 and 2019), and rates of HIV incidence and AIDS-related deaths have been reduced by 40% and 55% respectively. Global contraceptive prevalence rate has increased by 25% (UNFPA, 2019).

Intended audience

The statement is primarily intended for use by IPPF MAs across the world and the Secretariat. Additionally, it is aimed at all other civil society organizations, ministries of health, the broader development community including WHO and other UN agencies, as well as policy- and decision-makers, activists and researchers who are working to improve access to SRHR through its integration within national health plans and strategies towards UHC.

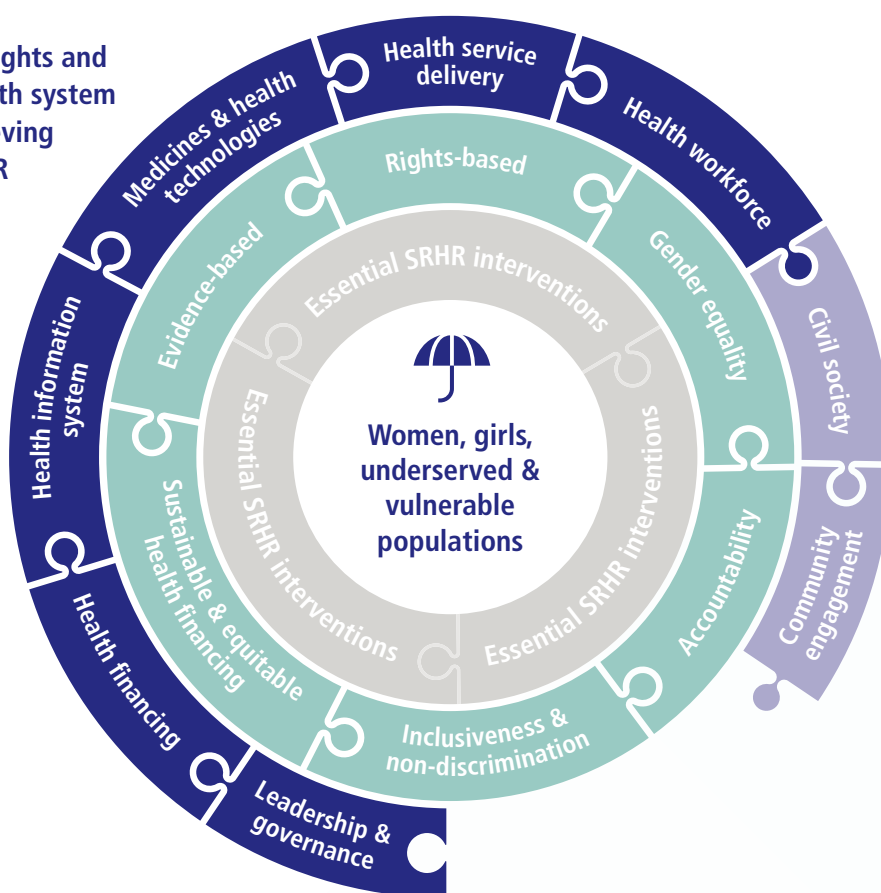
A people-centred and health-systems perspective to integrate SRHR in UHC

To advance universal access to SRHR within UHC, progress is needed to implement essential SRH interventions^d addressing the SRHR needs of all individuals, with a focus on those left behind,

and implement financing strategies that can sustain these efforts. In countries with limited resources, access to these interventions can be expanded incrementally, in line with the principles of progressive realization^{e,18} underlying UHC. In doing so, all steps from planning and budgeting, to the introduction, implementation, expansion and monitoring of essential SRH interventions are undertaken within the broad framework of health system strengthening. A health systems approach requires conscious actions in all of the six intertwined system building blocks as defined by WHO.¹⁹

To illustrate our approach, we propose a *human rights and people-centred health system framework* (see Figure 1 below), which articulates the key relations and principles for advancing towards, and achieving, comprehensive SRHR within UHC.

FIGURE 1: A human rights and people-centred health system framework for achieving comprehensive SRHR within UHC



^d Note that the term 'essential SRH interventions' is used in this statement in reference to the terminology that the Guttmacher-*Lancet* SRHR commission applied and is rooted in the ICPD Programme of Action and WHO's Reproductive Health Strategy. Each country will need to prioritize between these essential interventions based on local needs and resources. As argued throughout this statement, the process of prioritization must be transparent and based on principles of equity, inclusiveness and non-discrimination.

^e The progressive realization of UHC refers to the process of categorizing services into priority classes, expanding access to high-priority services to everyone and ensuring disadvantaged groups are not left behind (WHO, 2014).

The core of the framework represents, as with IPPF's work, that people and their health needs are at the centre. The first circle represents the need to implement interventions that address the SRHR needs of all, including women, girls, under-served and vulnerable populations.

The second circle highlights key principles to build an approach to SRHR integration in UHC that is based on: inclusiveness and non-discrimination, gender equality, evidence, accountability, sustainable and equitable health financing mechanisms, and human rights. Adopting a rights-based approach is essential in SRHR interventions which should be made universally available to all people to fulfil their SRHR needs, hence contributing to realizing their right to health.

The unclosed outer circle illustrates that achieving SRHR within UHC is contingent upon strengthening health systems and actions in all of the six core components of the WHO building blocks (i.e. leadership and governance; health financing; health information system; essential medicines and technologies; health service delivery; and health workforce¹⁹), as well as through community engagement and building a strong and thriving civil society.

The unclosed outer circle takes account of the fact that health systems are open systems. It also reflects that while health systems are central in implementing and providing access to essential SRHR interventions, a multi-sectorial approach is needed as comprehensive SRHR extends beyond the health system and involves other sectors, such as education.

Achieving SRHR within UHC relies on strengthening health systems and actions in all core components of the WHO building blocks: leadership and governance; health financing; health information system; essential medicines and technologies; health service delivery; and health workforce, as well as through community engagement and building a strong civil society.

Recommendations for Member Associations

Building on this framework, this section provides recommendations within each of the six WHO building blocks of health systems, as well as for civil society participation and community engagement, that may guide how MAs can advocate and support countries to develop contextualized roadmaps towards universal access to SRHR within UHC.

1. Advocate for and support the inclusion and integration of SRHR into UHC national strategic plans

Successful integration of comprehensive SRHR in the UHC agenda requires effective leadership, governance and support, coordinated at regional, national and sub-national levels.

- MAs should advocate for and support national governments in the development of a strong and costed national SRHR strategic plan as part of their national UHC strategies.
- MAs are well positioned to contribute to broadening the visibility and scope of SRHR in national dialogues on UHC by using every

opportunity to share successes, challenges and good practices in SRHR, and the impact of SRHR on women and girls' health and lives.

- MAs should aim to improve coordination and collaboration across sectors in support of integrating SRHR into UHC plans, including education, protection, water, sanitation and hygiene (WASH), environment, disaster responses, and other sectors – with national, regional and global partners.
- MAs have an important role to play in continuing to advocate at national level for governments to develop and implement policies, laws and initiatives that support rights-based, non-stigmatizing and gender-responsive SRHR programmes and interventions²⁰, thereby reducing barriers and increasing access to essential SRH services. Liberalizing abortion will be necessary to achieve universal access to safe abortion care and thus women's right to access services that protect their reproductive choices.²¹

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2. Promote and implement an integrated package of essential SRH services (IPES)

Moving towards UHC, countries must ensure that priority services are offered to and accessible for the entire population. Services must be available, accessible in both physical and financial terms, of high quality, acceptable, safe, and culturally sensitive. In addition, services offered should also be gender transformative, confidential, respectful, non-discriminatory and stigma free, and take into consideration the needs of diverse population groups, including women, girls, men, boys, under-served and marginalized groups, migrants and displaced populations, people living with disabilities, and the LGBTQI+ community. This requires addressing the economic, political, socio-cultural and geographic barriers that currently prevent or limit access to SRH care.

Together with community-based healthcare, primary healthcare (PHC) is often the first contact with health services, and realizing SRHR within UHC hinges upon a strong PHC approach⁷, which is crucial to ensure the efficient use of scarce health resources and make healthcare accessible in the most remote areas. A PHC system covers health services that are high quality, safe, comprehensive, integrated, accessible, available and affordable for everyone and everywhere, provided with compassion, respect and dignity by health professionals who are well trained, skilled, motivated and committed.²²

- As most essential SRHR interventions can be effectively delivered at the community or primary levels of the health system at a low cost to the government, MAs can contribute and lead in delivering the full range of services outlined in the IPPF Integrated Package of Essential Services (IPES). This includes SRH counselling, contraception, safe abortion care, STIs/reproductive tract infections, HIV, gynecology, maternal health, and SGBV services.²³
- MAs can demonstrate and promote the benefits of integrated service delivery models, which have been shown to increase service uptake, reduce stigma, provide better quality of care, and make more efficient use of health system resources.²⁴
- In addition, new service delivery models are needed to improve access to essential SRH services. Based on their experience, MAs have the potential to develop and promote the use of innovative and cost-saving approaches and tools (e.g. digital health, telemedicine), that can be integrated within PHC and expanded through task shifting and community health workers, who are often women, to provide access in hard-to-reach areas and for under-served and marginalized population groups.²⁵ These novel approaches should always build on evidence-based recommendations and ensure safety and effectiveness of the interventions.

Countries must ensure that priority services are accessible for the entire population. This requires addressing economic, political, socio-cultural and geographic barriers that currently prevent or limit access to SRH care.

3. Advocate for sustainable and efficient health financing for SRHR in UHC

An explicitly defined health benefits package (HBP) is the key strategic instrument to steer health systems towards achieving UHC. It determines a bundle of health services that can be financed and sustainably delivered, taking into account each country's specific circumstances and its health system's capacity.²⁶ The inclusion of SRH within an HBP means that services will be either fully or partially covered through public financing and will reduce the burden of out-of-pocket expenses to access these services. Hence, increasing access to SRHR within UHC requires that essential SRH interventions are prioritized and included in such packages. As available resources (financial and human) increase, countries should progressively expand the number of SRH interventions included in their HBP. At each stage of expanding coverage, costing analyses should be conducted to estimate the (annual) resource need for ensuring universal access to the services included in the HBP.

- MAs should advocate for an increase in national/public spending on health, in particular in LMICs.^{2,27} Expenditures in SRHR are cost saving investments rather than disbursements, and can achieve significant return on investment.²⁸
- MAs should advocate for the inclusion of SRH services in HBPs to ensure that these services do not become neglected and underfunded as a result of changes in external donor priorities. In countries with limited resources, which are often reliant on external donor funding, effective coordination of stakeholders and directing resources towards national SRHR priorities as stipulated in the HBP are critical.

- MAs should advocate for governments to raise and pool adequate resources for UHC to ensure a stable and predictable flow of funds to the health sector. MAs can advocate for the introduction of pre-payment mechanisms together with pooling of funds, which are both essential to reduce out-of-pocket payments rather than expenditures, and their negative impacts on access to services as well as catastrophic and impoverishing payments.²⁹

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4. Advocate to ensure a sufficient number of skilled, well-performing and equitably distributed SRH health workers

The health workforce is the foundation for achieving UHC, including universal access to SRH care. Shortages of health workers are limiting coverage of essential services, particularly in LMICs. Shortages are expected to continue and worsen if current trends persist.³⁰ Inequitable distribution of and mix of skills in the health workforce as well as gaps in training, motivation and performance of health workers represent additional challenges that many countries are grappling with.³¹

- MAs should advocate to ensure that a sufficient number of skilled health workers, including for the provision of SRH services, are recruited and trained to contribute to achieving progress on UHC at the national level. The distribution of healthcare workers, their training and skills should be adequate to match population needs and to provide people-centred and culturally appropriate care,³² with the responsibility for specific SRH services assigned to appropriately trained health workers.³³
- To rapidly and efficiently mitigate critical health worker shortages, MAs should advocate for governments to explore shifting/sharing certain tasks from higher- to middle- and lower-level health worker cadres.³⁴ They should also advocate for a more equal distribution of services across geographical areas and levels of care, and to ensure that adequate recognition and support is given to health workers, including community health workers.

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5. Ensure consistent availability of essential SRH commodities and supplies

In order to progress towards universal access to essential SRHR interventions, essential SRH medicines, supplies and equipment must be routinely made available at the relevant service delivery points in the health system. Data from, for example, Sub-Saharan Africa show persistent stock-outs of modern contraceptive methods in public health facilities.³⁵ Consistent supply also requires an understanding of how essential services are maintained in a time of crisis. The current COVID-19 pandemic has led to disruptions in SRH medicines supply chains and highlighted the fragilities of global distribution chains.

- MAs should advocate for ministries of health to review existing supply chain systems for each of the components of the essential SRHR interventions, and to address identified gaps.
- MAs play an important role in informing and influencing National Supply Plan activities. Through their participation in national supply strategies and decision-making processes, MAs can identify, share and address some of the challenges they face in SRH commodity security.
- MAs can engage in demand and awareness creation and behaviour change communication activities for SRH commodities delivered as part of the essential SRHR interventions to both stimulate community acceptance and foster community engagement and participation in improving access.
- MAs can play a key role in advocating for essential SRH medicines from the WHO list of essential medicines to be included in each country's national essential medicines lists, as well as measures to make these drugs universally affordable.

6. Strengthen health information systems and routine data collection

Strong health information systems (HIS) are critical for advancing the integration of SRHR within UHC. Well-functioning HIS provide reliable and timely health services data, including healthcare needs and associated resource demands for the health system, disaggregated by population needs, sex, and age, and analysed by gender. Strengthening data systems is important to inform decision-making and generate related policies, programming, budgets, and evaluation. They also form the basis of accountability for governments to achieve their commitments towards UHC. Countries therefore need to make appropriate investments in HIS to strengthen high-quality, timely and reliable research and routine data collection on key SRHR indicators.

- MAs should advocate for governments to generate and provide open-access data disaggregated by context-relevant variables. This could include income, sex, age, race, ethnicity, migratory status, disability, geographic location and other characteristics to allow for analyses of specific population groups to better understand who is left behind.¹⁷
- MAs, in partnership with like-minded civil society organizations (CSOs), play an important role in monitoring and evaluating the implementation of UHC commitments, ensuring that SRHR related data collection is adopted, that these efforts are also gender sensitive and inclusive, and that capacity to monitor and analyse relevant sex-disaggregated data can be sustained.

7. Promote the meaningful engagement of civil society and communities

The meaningful engagement and participation of CSOs and communities are key to ensure progress towards UHC at the national level, as well as to contribute to the successful planning and implementation of SRHR interventions that are responsive to local needs.³⁶

- The meaningful engagement and participation of MAs and CSOs are critical to ensure that decision-making and accountability mechanisms reflect the needs, priorities and diversity of population groups. MAs play an important role in ensuring that women are part of engagement and decision-making processes to reflect the specialized needs of women and girls in SRHR interventions.
- MAs play an important role in ensuring the establishment of transparent and participatory processes for including and prioritizing essential SRHR interventions in the essential health packages, based on high-quality, disaggregated data and documented experiences from local actors and communities.³⁷
- MAs and CSOs should aim to form strategic alliances with parliamentarians, parliamentary committees, and national/regional technical working groups/committees on health and UHC. The Inter-Parliamentary Union has expressed strong support for protecting SRHR than can be leveraged³⁸ and parliaments are important for decisions on resource allocations, establishing participatory budgets, and for influencing decision-making at all levels.³⁷
- MAs have also the potential to leverage experiences of successful SRHR integration, as well as barriers and limitations, across other settings and countries in order to inform, participate in and guide decision-making on UHC. Social mobilization through civil society and community engagement are imperative for generating demand for SRHR services and commodities³⁹ delivered as part of the essential SRHR interventions; they are also paramount to understanding and documenting social factors acting as barriers to use of existing SRH services, such as detrimental gender dynamics, religious beliefs and cultural norms.⁴⁰

Summary and moving forward

Achieving UHC represents an ambitious global effort which currently receives significant traction and political momentum. Although each country is at a different stage of implementation, as they take steps on the path towards UHC, new opportunities arise to advance and integrate a comprehensive approach to SRHR and essential SRH services. UHC reforms are inherently complex, but a people-centred and a health systems approach can help to identify key areas and actions that can be taken to advance SRHR integration in UHC. This statement has highlighted some of these areas and actions, but as these are context dependent, a deeper understanding of local circumstances and the specific needs of those currently left behind are crucial, and IPPF MAs are well placed to play a leading role in this process.

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As countries take steps on the path towards UHC, new opportunities arise to advance and integrate a comprehensive approach to SRHR and essential SRH services.

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Who we are

The International Planned Parenthood Federation (IPPF) is a global service provider and a leading advocate of sexual and reproductive health and rights for all. We are a worldwide movement of national organizations working with and for communities and individuals.

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