

How Universal Health Coverage Can Increase Access to Sexual and Reproductive Health Services in Sub-Saharan Africa

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KEY POINTS

- In recent years, governments across Africa have sought to shield their populations from the high financial cost of health care by implementing universal health coverage schemes.
- Universal health coverage cannot be achieved unless comprehensive sexual and reproductive health (SRH) care is included in national health plans.
- Kenya, Ghana, Ethiopia and Benin offer examples of how to integrate SRH into broader health coverage plans.
- Recommendations are offered to inform stakeholders' approach to integrating sexual and reproductive health care into national health coverage plans.

The Need to Integrate Sexual and Reproductive Health Care into National Health Coverage

Sexual and reproductive health and rights (SRHR) are an integral part of the right to health for all. To realise this right, every individual must be able to make their own choices about their bodies and sexual and reproductive health (SRH), free from discrimination, stigma, violence or coercion.¹ Availability and affordability of a wide range of health services are also critical for achieving equality and ensuring that needed care is accessible to all. To fully realise universal coverage, comprehensive SRH care must be included in any package of health services and be available to all members of a country's population.²

Universal Health Coverage

Universal health coverage (UHC) offers all individuals and communities high-quality health services without financial hardship. As described by the World Health Organization, UHC includes the full spectrum of essential services, "from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course."³

UHC is a target among the 17 Sustainable Development Goals (SDG target 3.8) that United Nations (UN) member states committed to achieving by 2030.⁴ The UN

Political Declaration on Universal Health Coverage states that UHC "is fundamental for achieving the Sustainable Development Goals related...to health and well-being," along with many other priority areas.^{5(para 5)} The Declaration calls on member states to, "Ensure, by 2030, universal access to sexual and reproductive health-care services, including for family planning...and the integration of reproductive health into national strategies and programmes."^{5(para 6B)}

The country-level UHC development process presents an opportunity to integrate comprehensive SRH care into the broader package of services, recognising these services are an essential component of the overall right to health. The provision of SRH services acts as a catalyst for achieving a range of health goals for the entire population, as well as realizing the demographic dividend⁶ in countries with a majority youth population.

Essential Package of Sexual and Reproductive Health (SRH) Interventions

The following interventions make up the essential package of SRH services, as defined by the Guttmacher–*Lancet* Commission on Sexual and Reproductive Health and Rights in 2018:

- Comprehensive sexuality education
- Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods
- Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care
- Safe abortion services and treatment of complications of unsafe abortion
- Prevention and treatment of HIV and other STIs
- Prevention, detection, immediate services 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

Guttmacher–Lancet Commission

The 2018 report by the Guttmacher–*Lancet* Commission on Sexual and Reproductive Health and Rights articulated a comprehensive and evidence-based vision for fully realizing SRHR in all countries.⁷ It is based on a new definition of SRHR that considers rights necessary for achieving sexual and reproductive health and recommends a broad package of essential SRH services (see box).

The Commission proposed an incremental approach that countries could use to eventually provide the full spectrum of SRH services, taking into account each country's particular resources and policy environment. This approach is in line with the UN Political Declaration on UHC, which "Reaffirm[s] the importance of national ownership and the primary role and responsibility of governments...to determine their own path towards achieving universal health coverage, in accordance with national context and priorities."^{5(para 12)}

Implementation of Universal Health Coverage Integrating SRHR

Africa's continental and regional institutions recognise the importance of frameworks that drive expansion of SRHR and improve access to related health services. More than a decade before the introduction of the UN's Sustainable Development Goals, the African Union's Maputo Protocol put forward an ambitious vision for the realization of comprehensive SRHR in Africa.⁸ For example, that legally binding protocol requires African Union member states to allow abortion to save the pregnant person's life, to protect physical or mental health, and in cases of rape, incest and foetal anomaly.

The Maputo Protocol and accompanying Plan of Action paved the way for progressive subregional SRHR policy frameworks, including the Southern African Development Community's (SADC) Strategy for Sexual and Reproductive Health and Rights in the SADC Region (2019–2030)⁹ and the draft East African Community Sexual and Reproductive Health Bill 2021.¹⁰ Several continental and subregional frameworks have incorporated or focused on specific issue areas identified as neglected by the Guttman-Lancet Commission, including comprehensive sexuality education, safe abortion care and interventions related to gender-based violence.

Examples of National UHC Implementation Efforts

There have been efforts to implement various UHC policy frameworks at the national level in some countries, but progress has been slow and uneven. Reasons for the slow pace include inadequate political will and budgets, opposition and pushback from religious and conservative groups, and a dearth of accurate and verifiable data.¹⁹ The following countries offer examples of efforts to roll out UHC schemes that include SRH services and the implementation challenges they faced.

Gaps in Access to Sexual and Reproductive Health (SRH) Services

Access to many SRH services has increased in Sub-Saharan Africa in recent decades. However, significant gaps remain, including in access to safe abortion care (both where abortion is legal and where it is restricted), comprehensive sexuality education, preventing and addressing sexual and gender-based violence, preventing and treating infertility and subfertility, and counselling for sexual health and well-being. Where SRH services are available, they may remain out of reach for the most marginalised, contributing to the following poor SRH outcomes:

- Maternal mortality in Sub-Saharan Africa—545 maternal deaths per 100,000 live births—remains far higher than the Sustainable Development Goal global target of less than 70 maternal deaths per 100,000 live births, and progress varies among and within countries.¹¹
- Only half of partnered or married women in Sub-Saharan Africa are estimated to have their family planning needs met with modern contraceptive methods.¹²
- Five countries in Sub-Saharan Africa allow legal abortion, up to a specified gestational limit, without justification requirements.¹³ In the others, abortion is restricted or prohibited, leading to unsafe procedures. An estimated 10% of maternal deaths annually in the region are attributed to abortion.¹⁴
- Women and girls in Sub-Saharan Africa contract more than 60% of new HIV infections in the region annually.¹⁵
- Sub-Saharan populations that are marginalised and stigmatised are at elevated risk for HIV (accounting for half of all new infections) and have less access to services.¹⁵
- One-third of women across Africa have experienced gender-based violence.¹⁶ The majority of such abuse is committed by an intimate partner, and evidence shows that intimate partner violence is related to elevated rates of HIV infection, unintended pregnancy, preterm birth and poor mental health.¹⁷
- Cervical cancer is the fourth most common type of cancer among women worldwide, and it is the most common cause of cancer-related mortality for women in most countries in Sub-Saharan Africa.¹⁸

Kenya

In 2020, Kenya launched its Universal Health Coverage Policy 2020–2030, with a goal of ensuring “all Kenyans have access to essential quality health services without suffering financial hardship.”²⁰ When the government developed its Reproductive Health Policy 2022–2032, it was described as a “welcome enabler of universal health coverage realisation in Kenya.”²¹ The reproductive health policy does not explicitly refer to sexual health or rights, and there are gaps in the package of services offered. However, it does address several elements of the Guttmacher-*Lancet* Commission’s essential package of SRH services.

Kenya’s reproductive health policy is aligned with other national policies and there is room to incrementally expand the services offered with concerted advocacy efforts. Importantly, the policy recognises that reproductive health services currently receive low priority in budget allocations. More domestic funding will be needed to fill the gap in international donor funds, which decreased when Kenya moved from a low-income to a lower-middle-income country in 2014. Kenya’s government also recognises there are challenges to implementation of the reproductive health policy posed by religious and cultural extremism in the country.

Ghana

Ghana’s National Health Insurance Scheme was introduced in 2003. Over the past 20 years, SRH services have gradually been included in the package of health services offered, following sustained advocacy by civil society organizations.*

While these hard-won gains are steps in the right direction, gaps and challenges remain. Where SRH services are offered, they may not be comprehensive, which can continue to lead to negative health outcomes. Although Ghana’s legal abortion grounds have fully complied with the Maputo Protocol for decades (i.e., allowing abortion to protect a pregnant woman’s physical or mental health, and in cases of rape,

incest and foetal anomaly), the provision of induced abortion is not widely covered by national health insurance, and women and girls typically pay the equivalent of USD\$20–80, depending on the facility and method.²² Those who are unable to afford this out-of-pocket expense may be left with no other option but to resort to a low-cost unsafe abortion or carry an unintended pregnancy to term.

As is true in many countries, conservative opposition in Ghana has affected the implementation of progressive policies and legislation on SRHR. In 2019, the Ghanaian government withdrew all guidelines and manuals related to comprehensive sexuality education²³—despite the fact that, as of 2017, 14% of young women aged 15–19 in Ghana had either given birth or were pregnant for the first time.²⁴ Efforts are being made by stakeholders to address this opposition through research, public campaigns and consultation; however, this example reinforces the need for broader political and societal engagement to increase buy-in and protect gains once made.

Ethiopia

In Ethiopia, the main route for achieving UHC is through provision of primary health care, and the Ministry of Health has integrated UHC into its health policies, guidelines and budget allocations. The ministry also developed a 20-year health sector strategy in 2015, titled *Envisioning Ethiopia’s Path towards Universal Health Coverage through Strengthening Primary Health Care*.²⁵

The current national Essential Health Services Package serves as a guiding framework to incrementally achieve UHC in the country.^{26,27} The grouping of reproductive, maternal, neonatal, child and adolescent health is one of the nine major components included in the package.

There has been remarkable progress on sexual and reproductive health indicators in Ethiopia, including maternal health, family planning, safe abortion, postabortion care and HIV treatment.²⁸ Ethiopia’s innovative Health Extension Programme delivers basic services, including family planning and other reproductive health care, across the country for free. Also, task shifting has

allowed a substantial proportion of family planning and abortion cases to be treated by trained health care providers who are not physicians.²⁹

In order to decrease health care costs for individuals, Ethiopia’s national health care financing strategy has been revised to provide free maternal, neonatal, family planning and other reproductive health services;³⁰ however, in reality, some out-of-pocket costs remain.³¹ Initiatives have been implemented to reduce these costs and promote health equity in accessing essential health services, including reproductive health care, by offering heavily subsidized services and fee waivers.

Despite Ethiopia’s progress on offering free health coverage, challenges remain. These include difficulties in providing expensive reproductive health services such as infertility care and reproductive cancer treatment and diagnosis; a low ratio of health care workers to overall population; and a stubbornly high unmet need for modern family planning.

Benin

In October 2021, legislators in Benin voted to decriminalise abortion under most circumstances, allowing the procedure up to 12 weeks’ gestation in cases in which a pregnancy “is liable to aggravate or cause a situation of distress that is incompatible with the woman’s or unborn child’s interest in the following areas: education, economic situation, career or social well-being.”³² Prior to the change in legislation, abortion was only allowed to save the life or protect the general health of the pregnant woman, and in cases of rape, incest or foetal abnormalities.^{33,34}

The expanded law makes Benin one of the most progressive countries on the continent in terms of legal grounds for obtaining an abortion. However, access to abortion and other SRH services still poses challenges, including insufficient funds budgeted by the government for SRH care overall.

Benin’s current health care financing system is split across several different types of coverage structures. Health insurance is not mandatory, and just over 8% of Benin’s citizens have some form of health insurance.³⁵ Health care provision reforms, starting in

*The services currently offered include information, counselling and services for infertility; information, counselling and services for sexual health and well-being; cervical and breast cancer treatment; maternity care and clinical methods of family planning.

2019, included the creation of new regulatory bodies overseeing the Ministry of Health, a renewed focus on public-private partnerships, and a new agency to plan and implement the national primary health care policy. The government has also launched mandatory health insurance focused on low-income individuals and those working in the informal sector, called L'Assurance pour le Renforcement du Capital Humain (ARCH).

The financing for these reforms has been met with some resistance.³⁵ One option for innovative financing to fund the ARCH program was to include an increase in taxes—on airplane flights and alcohol, for instance—to create more room in the budget for increased public investment and pro-poor spending. However, the financing has lacked transparency, and funding for a pilot project is not currently part of the national budget and is based on external contributions. Furthermore, the taxes proposed to finance the program may not be sufficient to cover the cost of insurance premiums the government is expected to subsidize. Benin's government will also need to balance providing funding for the ARCH program with ensuring adequate financing for preventive and primary health care.

Recommendations for Key Stakeholders to Improve Sexual and Reproductive Health Service Delivery In Universal Health Coverage

Providing UHC that includes a comprehensive package of essential SRH services is an achievable goal for countries in Sub-Saharan Africa. The country examples above, taken together with the Guttmacher–Lancet Commission recommendations, offer priority areas of action for governments, donors, civil society organizations, research institutions and advocates who are working toward meeting this goal. The first set of recommendations below outlines approaches that are applicable to all stakeholders; the second set details priority actions, recommending steps that can be taken by specific categories of stakeholders.

Recommended Approaches for All Stakeholders

- *Agreement on a comprehensive package of essential services:* Identify which services should be offered based on evidence of need.
 - *Incremental approach:* Recognise that an incremental approach to delivering a full package of services is recommended; it should prioritize national needs while being responsive to funding availability.
 - *Budget allocation:* Establish an adequate budget for SRH services that accurately reflects needs for commodities, technological investment, physical infrastructure, and staffing and training of health care providers. The budget should also support research and use of evidence to inform policy development.
 - *Health for all:* Make a deliberate effort to reach key populations and traditionally marginalised groups and to understand their specific SRH needs. These services traditionally target women of reproductive age; however, a comprehensive package must provide specific and targeted services based on the needs of all groups, including adolescents, men and the elderly.
- *Progressive policy framework:* Construct an enabling legislative framework that protects and promotes the rights of citizens. Legislation and policies should be evidence-based and reflect the informed needs and wants of citizens.
 - *Education and communication for social change:* Sensitise stakeholders to the importance of incorporating SRH services into UHC using evidence-based arguments. This should take place before and during service delivery to counter misinformation, reduce stigma, ensure interest in and use of services, and support continuity in usage, especially for long-term services such as family planning, treatment for HIV, and prevention and treatment of infertility.

Recommended Priority Actions for Specific Groups of Stakeholders

Policy and legislation

Governments: When conceptualising UHC schemes, consider the evidence demonstrating wide-ranging health, social and economic benefits of incorporating SRH services.

Governments/Ministries of Health: Prioritise the Guttmacher–Lancet Commission’s essential package of services for incremental inclusion in UHC schemes.

Governments: Include civil society organisations, underserved groups and other key stakeholders in policy development and implementation to strengthen health care systems and service delivery through community engagement.

Civil society organisations and other advocates: Leverage existing government commitments to global consensus documents and commitments to SRHR in national constitutions, including the right to health and nondiscrimination.

Donors, civil society organisations and other stakeholders: Adopt and use the Guttmacher–Lancet Commission’s definition of SRHR and essential package of SRH interventions to frame health coverage-related financing, programme design, policy analysis, advocacy and communications.

Donors: Encourage and support other development agencies and organisations to adopt the Guttmacher–Lancet Commission’s definition and intervention package into their own policies, strategies and funding mechanisms.

Donors: Include civil society organisations and marginalized populations along with development partners in policy and programme development and accountability measures.

Budgeting and funding

Governments and donors: Finance and operationalise policies and commitments that eliminate barriers to accessing SRH services.

Governments and donors: Ensure adequate financing of UHC, including SRH services, by implementing national health insurance, vouchers, free services at point of care and other mechanisms to decrease the financial hardship of health care services for individuals.

Civil society organisations: Advocate for governments to raise adequate resources for UHC and increase public spending on health care, in order to ensure a predictable flow of funds to the health sector.

Donors: Consider funding for civil society organisations to advocate for SRHR at multiple levels, both within the context of UHC and as a standalone issue.

Research and evidence

Governments, research institutions, civil society organisations and other advocates: Continue to invest in research and data to track progress and remaining gaps, and

to demonstrate the health, economic and social benefits of incorporating SRH services into national UHC schemes.

Research institutions, civil society organisations and other advocates: Demonstrate the importance of including comprehensive SRH services in UHC by researching the impact of gaps in services, especially on issues such as access to safe abortion, lack of investment in training of health care providers, access to modern contraception and lack of comprehensive sexuality education for adolescents and young people.

Governments: Ensure a robust monitoring, evaluation and learning framework to assess the impact of SRH services within UHC.

Donors, research institutions, civil society organisations and other advocates: Invest in research and dissemination of findings to counter opposition tactics to limit access to comprehensive SRH services.

Public engagement

Governments, civil society organisations and other advocates: Invest in engaging a broad range of stakeholders at all stages of

UHC development, from conceptualisation to implementation, to ensure buy-in and continued public support.

Governments and research institutions: Utilise community-led monitoring to provide up-to-date data on barriers to accessing services.

Innovation and technology

Governments and donors: Support technologies, products and service innovations that can catalyse rapid progress for SRH services, such as the use of self-care technologies and digital solutions.

Conclusion

UHC was conceived as a way to cushion a country's citizens, especially its most vulnerable members, from financial hardship when seeking health care. To be truly effective, UHC must strive to cover the full range of health care, including SRH services. In order to achieve this goal, it is critical that the services offered under this coverage reflect the needs of all members of society regardless of sex, age, sexual orientation, race or any other potentially discriminating

factor. Governments must also ensure that the provision of services is comprehensive, providing users with a broad range of options. This coverage should be supported by a wide-ranging outreach campaign to disseminate factual information across all levels of society to ensure sustained buy-in and support from communities.

All efforts to implement SRH in UHC must be supported by an enabling legislative,

policy and budgetary environment. Resources must be available for infrastructure, commodities, and recruitment and training of medical professionals. Not only will these steps aim to ensure high-quality services, they will also contribute to reducing stigma and discrimination, and encourage professionalism in the delivery of health care, particularly for marginalised groups.

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