CAPABILITY STATEMENT

UNIVERSAL HEALTH COVERAGE AND SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

Leaving no one behind

The Universal Declaration of Human Rights states that everyone has the right to a standard of living adequate for the health and well-being of themselves and their family, including medical care and necessary social services. Universal Health Coverage (UHC) means all people obtain the health services they need without suffering financial hardship, and universal access to sexual and reproductive health and rights (SRHR) is an integral part of this. SRHR has often been neglected in discussions on UHC, which fail to recognise that reaching UHC is only possible if the unique health needs of women and girls are met.

Fulfilling the right to health for all

The fulfilment of the right to health, including universal access to SRHR, must be the foundation and guiding principle of any health system to achieve UHC, which builds on the fundamental principles of equity, equality, and the right of all to access healthcare regardless of ability to pay. Without SRHR:

- each day **830** women die from preventable causes related to pregnancy and childbirth
- each year:
  - **214 million** women lack access to modern contraception[1]
  - **25 million** unsafe abortions take place
  - **350 million** people need treatment for STIs
  - there are **nearly 2 million** new HIV infections
  - **approximately 311,000** women die from cervical cancer[2]

Decades of research show the profound benefits of investing in SRHR[3]: weak health outcomes are strongly interrelated with gender inequalities, discrimination, violence, and lack of SRHR information and services. SRHR must be integrated into UHC to protect gains and accelerate progress towards the SDGs. At the heart of IPPF's work are the people it serves, especially the poor, marginalized and vulnerable. While recognizing the renewed commitments to strengthening Primary Health Care and health systems[4], there is concern that the right to health for all, on which UHC is grounded, has not been at the centre of UHC discussions.

Integrating SRHR into UHC

While governments are responsible for determining their own path towards UHC, this must be done in accordance with agreed human rights treaties and commitments, including respecting and promoting SRHR. Governments must also recognise the crucial role of civil society organisations (CSOs) in addressing the unique SRHR needs of the communities they work in, and commit to effective partnerships with CSOs in order to realise the 2030 Agenda. The integration of SRHR into UHC requires addressing the multiple legal and socio-cultural barriers that currently limit access to services and prevent women and girls from fulfilling their right to health; and discriminatory practices, restrictive beliefs and structural gender inequalities are exacerbated in fragile and crisis settings. Local CSOs have invaluable experience in challenging these barriers; their involvement in the development of national UHC strategies is critical.

IPPF's key asks

IPPF calls on governments, donors and partners to ensure that[5]:

1. **Human rights:** the right to health for all is respected, protected and fulfilled, regardless of socio-economic status, gender, race, sexual orientation or gender identity, HIV status, marital status, or any other grounds.
2. **Inclusiveness and non-discrimination:** principles of inclusiveness, non-discrimination, non-violence, social justice and solidarity are embedded in UHC.
3. **UHC package:** a comprehensive package of SRHR interventions is fully integrated as part of UHC national strategies, policies and programmes of action - SRHR services are health promotive, preventive and cost effective.
4. **Structural & socio-cultural barriers:** obstacles in accessing healthcare - including discrimination, legal barriers, and poor information, education, health-seeking behaviour, decision-making power and inadequate services - are addressed.
5. **Healthcare workforce:** healthcare workforces are strengthened, particularly community health workers who play a key role in reaching underserved populations.
6. **Financial protection:** healthcare expenditures are minimized, including access costs, to prevent financial hardship especially for women, girls and marginalized groups.
7. **Domestic funding:** public investments in health expenditure reach 5% of GDP, and health funding is monitored to ensure UHC is achievable through community-level services.
8. **Community engagement:** communities are actively engaged as their participation is key to building healthcare that responds to local needs.
9. **Accountability:** strong accountability frameworks and effective monitoring and evaluation mechanisms are adopted, to guide the development of UHC policies and strategies.
10. **Evidence-based approach:** quality, timely and reliable research and data systems are improved and strengthened, and shaped by technology.

1. Guttmacher Institute: Factsheet on investing in contraception and maternal and newborn health, 2017: https://www.guttmacher.org/fact-sheet/adding-it-up-contraception-mnh-2017
2. WHO: Factsheet on HPV and cervical cancer, 2019: https://www.who.int/en/news-room/fact-sheets/detail/human-papillomavirus-(hpv)-and-cervical-cancer
3. Starrs, Ann M., et al. "Accelerate progress - sexual and reproductive health and rights for all: report of the Guttmacher-Lancet Commission." The Lancet 391.10140 (2018): 2642-2692
4. WHO, UNICEF. "Declaration of Astana." Global Conference on Primary Health Care. 2018.
5. IPPF's key asks on UHC available at https://www.ippf.org/blogs/universal-health-coverage-uhc

Future steps

Countries are at different stages of integrating SRHR into their UHC plans, but health systems strengthening initiatives have often neglected SRHR as part of their "essential services packages". The next step will be a challenge: how will UHC take place at national and local levels, and how will gender and SRHR be meaningfully integrated in these processes? All states should support:

- the reaffirmation of the right to health for all
- full gender equality
- fulfilled sexual and reproductive health and rights
- the right of women to control their sexuality

IPPF is committed to addressing the problems that prevent SRHR being included in UHC strategies, and is leading global and local initiatives that challenge access to SRHR:

- the drivers of inequities, especially gender and power dynamics
- regulatory and legislative barriers
- financial obstacles and out of pocket expenditures
- the limited availability, long distances and poor quality of services
- stigma, discrimination and socio-economic status

Internationally, IPPF influences key resolutions and political declarations, ensuring that the right to health for all, gender equality and SRHR are meaningfully included in UHC strategies. Nationally, IPPF works closely with Members Associations to ensure that an integrated package of SRHR interventions is included in national policies and action plans, and that learning around UHC is shared across the Federation. IPPF also continues to play an active leading role in key UHC fora, including:

- IPPF UHC Working Group
- Civil Society Engagement Mechanism for UHC 2030
- Global Action Plan Civil Society Advisory Group
- Alliance for Gender Equality and UHC
- WHO Guidance on SRHR Integration Core Working Group
- Task team of UHC2030 for UNGA political declaration negotiations

Published June 2019
IPPF
4 Newhams Row London SE1 3UZ United Kingdom
tel: +44 20 7939 8200 fax: +44 20 7939 8300 www.ippf.org
UK Registered Charity No. 229476

Photos: Afghanistan: IPPFSAR / Kenya: IPPF/Jon Hopkins

Afghanistan: Addressing gender-based violence to reach UHC

Afghanistan is a low-income country; access to its very limited healthcare is further worsened by gender, social and economic disparities: achieving UHC will be impossible if these issues are not addressed.
Gender-based violence (GBV) is pervasive, stemming from complex inequalities, beliefs and practices, combined with poverty and poor awareness. The government decreed in 2009 to eliminate violence against women, including child marriage and rape. IPPF in Afghanistan, the Afghan Family Guidance Association (AFGA), is a leading CSO addressing GBV. AFGA reaches out to communities, religious leaders and local government to influence knowledge and attitudes towards GBV, providing:

- integrated and stigma-free SRHR services, especially in overlooked communities
- specialist counselling training that responds to psycho-social needs
- referral pathways with government agencies and CSOs to expand HIV/STIs services and healthcare
- standard operating practices that strengthen communities' multi-sectoral working groups
- sensitization of key stakeholders on gender inequality: the Ministry of Haj & Islamic Affairs plays a leading role in changing attitudes

Kenya: Investing in adolescent and youth-friendly SRHR

Kenya has a rapidly growing population, with 52% under 20 years of age. Providing young people with universal access to education and healthcare, including SRHR, increases opportunities for sustainable development. The government has planned affordable healthcare for all, to achieve UHC by 2030: insurance and tax financing will support health protection, and SRHR is a priority. However, inequalities are high, coverage for vulnerable populations is inadequate, funding is insufficient and coverage is variable, especially between urban and rural areas. Cultural and religious values also need to be challenged. IPPF in Kenya, Family Health Options Kenya (FHOK), works in the community providing youth-centred services and comprehensive sexuality education (CSE) in and out of school:

- its Nairobi Youth Centre provides HIV/STI services, counselling, pregnancy tests and contraceptives, as well as vocational and life skills
- the Friends of Youth mentoring project in the Nairobi slums discusses SRHR issues with teenage girls, domestic workers and sex workers, and provides services; in schools, mentors establish health clubs and train peer educators
- the Young Men as Equal Partners project transforms attitudes of young men and boys, sensitizing and getting buy-in from village elders, church leaders and local chiefs; male "champions" are trained and form health clubs, and local governments incorporate activities into their district plans