



MAKING UNIVERSAL HEALTH COVERAGE WORK FOR WOMEN AND YOUNG PEOPLE

Putting Sexual and Reproductive Health at the Centre of UHC Reforms in Asia-Pacific

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Universal health coverage (UHC) cannot be achieved if sexual and reproductive health and reproductive rights are left behind. Countries wishing to meet UHC targets should ensure that access to sexual and reproductive health is truly universal. It should be comprehensive, by combining a broad range of services including health promotion, prevention and treatment; it should be responsive to specific needs of different population groups; and accessible to all, including the most vulnerable. In Asia and the Pacific, the United Nations Population Fund (UNFPA) commissioned a review of access to sexual and reproductive health services in the context of achieving the Sustainable Development Goal 3.8 by 2030: "Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

The study evaluated the achievement of universal access to sexual and reproductive health in Asia and the Pacific with a specific focus on six countries (Bangladesh, Cambodia, Indonesia, Mongolia, Thailand and Viet Nam). All selected countries have demonstrated a willingness to move towards UHC by adopting health financing strategies and policies aimed at increasing access and financial protection. To carry out this analysis, a framework disaggregating UHC into three health system goals was used. It considered a) the effective coverage of services; b) equitable access to services; and c) financial risk protection. Access to sexual and reproductive health services was assessed using 11 services as indicators.

Overview of six countries

The six countries in the analysis all adopted policies that include more or less explicit UHC goals, such as full population coverage by health financing schemes. While they are all at different stages of reform, there is an overall trend towards more unified financial risk protection mechanisms with single purchasers (e.g. the National Health Security Office in Thailand or the National Health Insurance scheme in Indonesia). Yet, at the national level, a number of fragmented schemes still coexist (ranging from voucher schemes to health equity funds and community-based health insurances), often covering different population groups with diverse benefits.

Recent efforts have led to significant progress for some sexual and reproductive health indicators, but a more thorough analysis reveals gaps in terms of statutory coverage. While maternal health services are often included in the schemes, or delivered for free at public health facilities, the inclusion of other essential sexual and reproductive health services is still lagging behind, in particular for family planning services, termination of pregnancy, cervical cancer screening and treatment, Human Papillomavirus (HPV) immunization, HIV treatment, prevention of mother-to-child transmission (PMTCT) of HIV and micronutrients supplementation during pregnancy.

BANGLADESH



UHC Legislative Framework

Health financing strategy in 2012; goal of Universal Health Coverage by 2032

SRH financial risk protection landscape

- Subsidized Social Health Insurance for the poor (move towards a social health insurance model with single purchaser)
- Maternal Health Voucher / Demand Side Financing scheme for pregnant women
- Community-based and micro health insurance schemes

CAMBODIA



UHC Legislative Framework

National Social Protection Strategy for the Poor and Vulnerable in 2011 and National Social Protection Policy Framework 2016-2025 in 2016

SRH financial risk protection landscape

- Public facilities charge co-payments for SRH services, with exemptions for the poor
- Health Equity Funds for the poor
- Community-based health insurance schemes for near-poor informal sector workers
- Voucher schemes for poor women
- Social Health Insurance for civil servants and formal sector workers

INDONESIA



UHC Legislative Framework

National Social Security Reform in 2004

SRH financial risk protection landscape

- National Health Insurance with a coverage target of all the population (social insurance beneficiaries, civil servant, military, formal sector) with different premiums rates

MONGOLIA



UHC Legislative Framework

Long term strategy for the development of social health insurance (2013-2022) adopted in 2013

SRH financial risk protection landscape

- Mandatory Social Health Insurance with coverage of 90% of the population with subsidized premiums for children under 16, pensioners, mothers of children up to two years of age, and the poor

THAILAND



UHC Legislative Framework

National Health Security Act 2002

SRH financial risk protection landscape

Under the National Health Security Office:

- Social Security Scheme for the formal sector;
- Civil Servants' Medical Benefit Scheme for active and pensioned civil servants;
- Universal Coverage Scheme for the poor, the elderly, disabled, children and informal sector workers as well as previously uncovered population
- Voluntary Migrant Health Insurance scheme targeting both documented and undocumented migrants

VIET NAM



UHC Legislative Framework

Health Insurance Law in 2008, revised in 2014

SRH financial risk protection landscape

- Compulsory Social Health Insurance scheme covering formal employees (contributions through payroll); the poor, children under six and the elderly (subsidized premiums); as well as other population groups (who have to buy membership, subsidized depending on income)

In the next section, progress towards universal access to sexual and reproductive health in Asia and the Pacific is outlined in light of the three health system goals for UHC (effective coverage of; equitable access to; and financial risk protection for sexual and reproductive health services) with a specific focus on the six countries in the study.

SEXUAL AND REPRODUCTIVE HEALTH AND UHC: KEY LESSONS FROM ASIA AND THE PACIFIC

Effective coverage of sexual and reproductive health services

The notion of effective coverage of sexual and reproductive health services goes beyond statutory coverage and refers to both inclusion as a benefit covered by a health financing mechanism and as the availability of health service delivery. The study in particular reveals that:

- **The Asia-Pacific region as a whole has been successful in realising sexual and reproductive health and reproductive rights through the promotion of voluntary family planning services.** The regional average contraceptive prevalence rate (69%) and proportion of satisfied demand for family planning (87%) have been consistently higher than the global trend since the 1990s. Nevertheless, some countries are left behind in meeting the demand for contraception, including Afghanistan (52% of demand satisfied), Timor Leste (53%), the Pacific Island States (between 43% in Samoa and 64% in the Solomon Islands), and Pakistan (65%).
- **In spite of a low regional adolescent birth rate, access to contraceptive services and information for teenagers remains a point of concern.** Only one in five sexually active adolescent girls in Asia-Pacific is protected from unintended pregnancy. As a result, among the six countries in the study, four countries have shown increasing adolescent birth rates since 1991.
- **Most Asian-Pacific laws are restrictive when it comes to pregnancy termination.** Restrictions range from abortion prohibition except to save a woman's life, to abortion permission in order to preserve her health, including mental health. Pregnancy termination services are usually not included in benefit packages. Only six countries across the region grant unrestricted access to abortion.

Coverage and Access to Sexual And Reproductive Health across Countries

BANGLADESH

- Continued rise in out of pocket expenditures and drift of patients to the private sector.
- Increase in equity and coverage of services through vouchers for maternity care.
- SRH services beyond maternity care only partially covered, and not included in the social insurance benefit package. User charges for SRH services are likely to remain in place.

CAMBODIA

- Universal coverage of maternal health services supported through specific policies and programs; rapid increase in skilled birth attendance.
- Gaps in prevention and treatment of cervical cancer and addressing violence against women.
- No user fees exemption in the private sector, leading to high cost of SRH services.

INDONESIA

- Overall service utilization increased by 60% in 2014-2015, but evidence related to SRH services utilization is limited.
- Youth-friendly services were introduced at primary care level, but access to SRH services for adolescents is still restricted.
- Regional inequities in health services coverage remain high.

- Regionally, significant but unequal progress has been achieved in terms of maternal health services.** There are large variations in maternal mortality, with a nine-fold difference between estimated maternal mortality ratios in Thailand and in Bangladesh. Contributing factors include uneven quality, access to and utilization of antenatal, obstetric and postpartum care. In terms of antenatal care, good progress was achieved between 1990 and 2014, specifically for South East Asia (with an increase from 45% to 84%) but less so in South Asia (from 23% to only 36%). Despite the lack of data on the full package of antenatal services provided, concerns can be raised about their quality and comprehensiveness.
- Skilled Birth Attendance (SBA) coverage, has improved in Asia and the Pacific.** It more than doubled over the past five to seven years. While there is no aggregated data on access to emergency obstetric care in the region, individual countries such as Cambodia show improvements. However there is limited data on postnatal care coverage, calling for enhanced information systems to monitor coverage of sexual and reproductive health services, including postpartum family planning.
- Coverage rates for HIV and other Sexually Transmitted Infections (STIs) services have evolved differently.** HIV incidence rate decreased by more than 50% since the late 1990s, however other STIs indicators trends remain above global levels, and even increased in some countries. While the coverage rates for HIV diagnosis and treatment have increased overall, they remain low in certain countries, notably Indonesia and Bangladesh. STIs detection and treatment services have increased in the countries included in the study and in Asia and Pacific in general, but more recent funding decreases have led to reduced STIs service delivery rates.
- Cervical cancer prevention, screening and treatment have been launched but coverage presents gaps.** While immunization against HPV has been introduced in most Asian countries, major gaps remain in the coverage of prevention and treatment of cervical cancer at all levels. Screening programs have been launched in most of the six study countries and include integration through a single-visit approach for diagnostic and treatment. Yet their coverage remains very low.
- Services for gender-based violence are lacking.** Such services generally do not generate out of pocket expenditures. However, health system preparedness to respond to gender-based violence is less than optimal: integrated approaches such as One-Stop Crisis Centres have been nationally scaled up only in Thailand.

MONGOLIA

- Substantial progress in maternal health.
- Declining access and use of family planning, rising adolescents birth rates, high abortion rates and high incidence of STIs. Stock outs of contraceptives are relatively common.
- Maternity care provided free of charge at primary health facilities; secondary and tertiary services included in Social Health Insurance but with many exceptions. The population thus has to pay for those services that are not included in the benefits package.

THAILAND

- Almost all SRH services included in Universal Coverage Scheme, leading to impressive results and narrowing of equity gap in family planning, maternal health, and response to HIV.
- High incidence of unsafe abortion persist, due to misconceptions about the legality of safe abortion services.
- Migrant workers still face healthcare access barriers, despite voluntary scheme.

VIET NAM

- Limited SRH services coverage through Social Health Insurance (out of pocket payments or no inclusion in the benefit package).
- Special programs for specific benefits (e.g. family planning program for ethnic minority women and poor women living in remote areas).
- Despite access to contraception, adolescent birth rates have increased and high rates of pregnancy termination are observed, especially performed in the private health sector.
- Despite success of family planning programs for ethnic minorities, inequities remain for some SRH areas, particularly maternity care.

Equitable access to sexual and reproductive health services

Equity is a cornerstone of UHC: it guarantees that anyone can use health services according to their needs. In Asia and the Pacific:

- **There are large access gaps across economic quintiles for sexual and reproductive health services, including family planning and maternal health services.** In all countries in the study except Indonesia, women in the lowest wealth quintile are more likely to use modern contraceptives than women in general, which could be attributable to the success of UHC policies targeted at poorer and more vulnerable people. Social inequities decreased for some indicators like contraceptive prevalence and satisfied demand. But they increased in other areas, e.g. the equity gap for skilled birth attendance increased in countries like Bangladesh and Cambodia between 2010/2011 and 2014.
- **Place of residence seems to be the most important determinant of sexual and reproductive health access.** Women in rural and remote areas encounter barriers when they want to access family planning services in particular, and antenatal care services. Importantly, for large island countries in the region, discrepancies may not appear across the rural/urban divide, but between regions with high and low service coverage.
- **Some groups in vulnerable situations are systematically left behind** when it comes to coverage and access to sexual and reproductive health services:

Ethnic minorities. Even when health financing schemes offer statutory coverage to ethnic minorities, they can experience barriers in accessing sexual and reproductive health because of cultural factors or stigma and discrimination by health care personnel. Language and transport can also be obstacles to access.

Migrants. They can face both formal and informal barriers in accessing sexual and reproductive health services. They are not necessarily included among the beneficiaries of health financing schemes (and only a minority of countries have ratified the 1990 UN Convention on the Rights of all migrants workers and members of their families, encompassing equal access to social and health services). On the other hand, even when they are granted access to services, they do not necessarily make use of them, due to health care provider stigma, cost and availability of services, or lack of time and shyness to access services.

Refugees. While 54% of the global refugee population lives in Asia and the Pacific, there is a gap between the right to social protection and access to services for them. Yet there is limited information on their effective access to health services.



Financial risk protection for sexual and reproductive health services

Financial risk protection is analysed under the lens of both the inclusion of sexual and reproductive health services in benefit packages and the pooling of funds at national level. It was found that:

- **We do not know the exact amount of neither governments' nor households' expenditure on sexual and reproductive health.** Due to methodological limitations, we note a lack of data on expenditure on sexual and reproductive health services. In particular, in National Health Accounts, out of pocket expenditure cannot be disaggregated by population group or by services.
- **Sexual and reproductive health services are included in different health financing mechanisms.** Sexual and reproductive health services can either be covered by social health insurance schemes or delivered in public facilities (for free or at a subsidized rates). In some cases, services that are excluded from one benefit package can be covered by another health financing mechanism. This is the case for publicly delivered sexual and reproductive health services when health insurance schemes do not cover them.
- **Including sexual and reproductive health in benefit packages does not necessarily ensure service access** because this does not necessarily mean that the full spectrum of sexual and reproductive health services can be accessed completely free of charge. Some sexual and reproductive health services often remain uncovered or patients are charged user fees. Similarly, statutory coverage by a health financing mechanism does not mean that those services are available to all. In particular, as we can see in the table below, cervical cancer screening is not yet made widely available.

This table summarizes the coverage status for some sexual and reproductive health services in the six study countries.

<i>Services</i>	<i>Coverage status</i>
<i>Maternal health</i>	Covered everywhere (antenatal, obstetric and postpartum care).
<i>Family planning</i>	Coverage of family planning services can be universal (Thailand, Indonesia) but is often patchy; included or subsidized for some population groups only (Cambodia, Mongolia, Viet Nam) or delivered by an underutilized public sector (Bangladesh).
<i>Fertility regulation</i>	Services such as emergency contraception, pregnancy termination, menstrual regulation and post-abortion care are generally not covered by health financing schemes. Benefits packages tend not to cover pregnancy termination even in countries with less restrictive access to fertility regulation services.
<i>Preventive services, including for cervical cancer</i>	Often neglected by health financing schemes (including activities such as prevention of mother-to-child transmission of HIV and micronutrient supplementation during pregnancy). HPV immunization is not included into routine immunization programs in the six countries; although it is covered under social health insurance benefits in Mongolia and Thailand but with low coverage. Low coverage of national cervical cancer screening programs (included in benefits package in Thailand, Mongolia and Indonesia; delivered for free in public facilities in Bangladesh but limited availability; waiver programs in Cambodia).
<i>STIs treatment</i>	Focus on epidemic control. Services often inadequate in the public sector and patients tend to use private sector providers (as in Cambodia and Viet Nam).
<i>HIV care</i>	Often dependent on Global Fund to Fight AIDS, Tuberculosis and Malaria (but some countries like Thailand are paying for HIV services using their national pool of resources for health).

Pooling of funds for UHC

While all six study countries have taken steps towards national / social health insurance models covering (some) sexual and reproductive health services, there is still a high degree of fragmentation at country level. This is particularly striking in Bangladesh and Cambodia, where services are paid using both the national budget and third-party payers. In other countries like Viet Nam and Mongolia, pooling is ensured by long-established social insurance mechanisms combining premiums and Government transfers. Thailand has a high degree of pooling (even if there is still no unified mechanism between payroll contribution and government funded pools) and a single purchasing agency. However, migrants are still included through a separate system. Overall, in Asia and the Pacific, the necessity to move towards greater efficiency gains by adopting unified health financing mechanisms with a greater pooling still remains to be addressed.

Recommendations

As countries in Asia and the Pacific are moving towards UHC, Governments and development partners should make sure that sexual and reproductive health services are a core component of their strategies. In particular, attention should be brought to adolescents and young women when designing benefits and extending population coverage. Equity should also be a cornerstone of UHC and sexual and reproductive health reforms, with a specific focus on migrant populations. Finally, tackling fragmentation in health financing landscape will contribute to delivering a greater coverage and to facilitating access to sexual and reproductive health services.

Based on this analysis, we recommend Governments and development partners to:

MULTI-SECTOR APPROACH

Recognise the overlap and complementarity between UHC and sexual and reproductive health, as well as the areas that are out-of-scope for UHC. UHC cannot be achieved without sexual and reproductive health, but at the same time increased efforts beyond the health sector are needed to guarantee universal access to sexual and reproductive health services and information.

SERVICE COVERAGE

Include family planning services under benefits of health financing mechanisms. In particular, ensure that contraception is accessible for adolescents, who generally have a high unmet need for contraceptives, as well as a high rate of unsafe termination of pregnancy.

Include in national health financing mechanisms preventive services for sexual and reproductive health, such as quality services for cervical cancer prevention, prevention of micronutrient malnutrition among adolescent girls and pregnant women, and prevention of STIs and HIV infection.

POPULATION COVERAGE

Prioritise service delivery for adolescents and the financing of HPV immunisation, sexuality education and access to contraception, including emergency contraception, provided in an acceptable and accessible way to all without social and financial barriers.

Close the equity gap through inclusive and targeted health programming. Comprehensive health financing mechanisms should in particular aim to reach the very large populations of ethnic minorities, migrant workers and refugees in the Asia-Pacific region.

FINANCIAL RISK PROTECTION

Consider a bold approach to creating universal access to financial risk reduction schemes without complex eligibility requirements, premium structures and tiered subsidies, in order to achieve high coverage levels at minimal transaction costs. Pooled health financing schemes should be promoted.

EVIDENCE

Increase the evidence-base for UHC and sexual and reproductive health. This should include evidence on: out of pocket expenditures for sexual and reproductive health services that are not covered in schemes; reasons for populations to bypass public services beyond financial constraints; and identification of sexual and reproductive health cost-services. Regional cooperation should be promoted.