Achieving sexual and reproductive health and rights through universal health coverage

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The 2030 Agenda for Sustainable Development was adopted by the United Nations general assembly in September 2015. The agenda encompasses internationally agreed development aspirations – the Sustainable Development Goals (SDGs). The health targets of the SDGs are not merely ambitious in themselves; they are configured with a very considerable range of other, hugely expensive global issues: 17 goals and 169 targets covering nearly every important aspect of human well-being, both physical and relational.

Within the health sphere, by the end of the SDGs in 2030, the ambition is that the AIDS epidemic and other communicable diseases should have been ended, child and infant mortality should be significantly reduced, and universal health coverage with financial protection should be in place for all. But the Joint United Nations Programme on HIV/AIDS (UNAIDS) 5-year 'Fast Track' plan for front-loading resources in order to build on progress against the HIV/AIDS pandemic is already faltering – surely evidence of the squeeze being exerted by the most urgent non-health issues (eg, SDG 13: climate action), together with an unpropitious political climate for Official Development Assistance generally.

Whatever political embarrassment it might provoke, we must confront the inescapable conclusion that the SDGs are aspirational rather than a compulsory commitment to a programme: the hard choices will become larger in number and more anguished. The overarching question, then, is this: how, within existing and foreseeable resource constraints, can we maximise positive health impacts that are broad-spectrum and do not compromise existing and worsening health crises? We suggest that one of the most far-reaching, and indeed sustainable, investments we can make to health in developing countries is through a concerted effort to improve sexual and reproductive health and rights (SRHR), the concept of human rights applied to sexuality and reproduction. This is hardly a revolutionary call,[1 2] but present conditions – financial and political as well as health – give its character as a priority new salience and urgency.

SRHR is 'broad-spectrum' because it entails both the physical and relational aspects of preventive health – and many of the advances it comprises are at least potentially sustainable at very low cost, including reducing unwanted pregnancies and unsafe abortions; retarding the spread of HIV and other sexually transmitted infections; reducing the sexual exploitation of minors and people with disabilities; providing available and affordable contraception and counselling; providing pre- and postnatal care and advice; providing skilled attendance during childbirth; reducing gender-based violence; and advocating increased condom use.[3] SRHR initiatives also have the potential to amplify, and in turn benefit from, work to secure SDG 5: 'Achieve gender equality and empower all women and girls'.

Of course, difficulties abound – not least the reinstatement of the US government's 'global gag rule'[4] in extended form, but also the fact that there is no authoritative body to prioritise and direct global SRHR interventions. Both the WHO and the United Nations Population Fund (UNFPA) have a mandate for advancing SRHR globally and an important role in doing so, but struggle to tackle issues around abortion and adolescent sexuality in particular. In recent dialogues with policymakers representing health ministries in Eastern and Southern Africa, facilitated by us, a challenge common to all is how to maximise health outcomes without alienating any of their larger constituencies or compromising management of other urgent health issues. So while economically poor

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women in the countryside lack access to basic reproductive health services, a growing urban middle-class expect resources to be spent on non-communicable diseases such as diabetes or heart conditions. Striking this balance will undoubtedly be difficult even for the boldest and most progressive health ministers. To this must be added very considerable resistance, driven by culture and social norms, to certain aspects of the SRHR agenda (most notably safe abortions and same-sex relations). The commitments to health and SRHR that countries have made in international conventions and regional agreements do not always play well on the ground, so political leaderships must often tread very carefully.[5]

So how best to advance a thematic agenda with so many particulars requiring action, especially in southern African states where conditions and expectations are anything but uniform? We suggest that the best means is through the way each state structures the establishment or strengthening of Universal Health Coverage (UHC) for its citizens. There are a number of reasons why this is the most pragmatic means of progressing SRHR. The first is the increasing expectation, within states as well as internationally, to extend accessibility and affordability of at least the fundamentals of healthcare as a citizen right. The most prominent SRHR issues, especially maternal health and gender equity, are not new to debates about health service provision,[6,7] but the combination of SDG 3 (health) and SDG 5 (gender equality), together with the drive toward UHC, present us with an opportunity to approach them in a systematic and structured fashion.[8]

The second reason is that because so many SRHR issues entail behavioural change over extended periods. Because gender disparities in health services have such pervasive and damaging outcomes to the health of entire nations, they need to be embedded in nations's health policies and placed at the heart of health and health education provision. UHC can provide the framework for this.

Finally, the UHC umbrella would enable Health Ministries in Africa to make at least some provisions under the 'health' rubric in places where 'sexual and reproductive rights' tend to meet resistance that is driven by cultural and social norms.

Of course, each nation would need to craft its own SRHR-UHC agenda to meet particular health and politico-legal circumstances; and a systematic approach will be vital to ensuring that diminishing resources are channelled strategically, rather than in piecemeal fashion. And an important caveat: for behaviour modification programmes, there is no substitute for evidence-based research, since neither time nor resources must be wasted.

There is no single, best, or most urgent SDG health priority; and what we are advocating is neither a 'silver bullet' for the health issues that beset developing countries (and many southern African states in particular), nor a health *sine qua non*. Instead, SRHR should be viewed as one of the most effective means, within any UHC worthy of the name, to achieve widespread and enduring positive health outcomes at the low end of the cost spectrum.

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