PERSPECTIVE

Universal Health Coverage: Are We Losing Our Way on Women's and Children's Health?

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Our children are our future and one of the basic responsibilities is to care for them in the best and most compassionate manner possible.

—Nelson Mandela[1]

If women are denied a chance to develop their full human potential, including their potential to lead healthier and at least somewhat happier lives, is society as a whole really healthy?

—Dr. Margaret Chan[2]

This commentary argues that current efforts to achieve universal health coverage (UHC) risk losing some of the gains achieved on women's and children's health. Currently, there is a failure to prioritize women's and children's health in the vision for primary health care that is being promoted to achieve UHC. By failing to prioritize actions to protect the health of women and children, efforts to achieve primary health care—and thus UHC—are diluted. As a consequence, despite our good intentions, we move farther away from achieving health for all. This commentary encourages a rethinking and a move toward a diagonal approach to primary health care, with interventions for women's and children's health driving system improvements that will better achieve UHC.

Global commitments to prioritize women's and children's health

The prioritization of women's and children's health has both scientific and legal roots that indicate that it is essential for achieving the highest attainable health for a nation's population. One of the most notable expressions is in the Universal Declaration of Human Rights, where the right to health is defined as a comprehensive package of rights providing "a standard of living adequate for the health and well-being of [individuals] and [their families], including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond [their] control."[3] Since the 1978 Declaration

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of Alma-Ata, there has been broad agreement that primary health care is a prominent driver of health for all and UHC.[4]

Public health professionals have recognized for decades that prioritizing women's and children's health is an effective and efficacious means of improving public health generally. As Syed Masud Ahmed et al. conclude in their 2016 study of 10 countries that achieved Millennium Development Goals 4 and 5, interventions that achieved major reductions in under-five child mortality and maternal mortality between 1990 to 2015 contributed to "improvements in population-based coverage of high-impact interventions in health and other sectors."[5] This study merely confirmed what a 2010 study of 68 had found.[6]

The Sustainable Development Goals (SDGs) affirm the importance of women's and children's health by adopting indicators for the achievement of Goal 3 that are similar to those for the health-related Millennium Development Goals (4 and 5), which focused specifically on women's and children's health.[7] The first three indicators for SDG 3 relate to maternal mortality, births attended by skilled health personnel, and the preventable deaths of newborns and children under five.[8] Furthermore, indicator 3.8.1, specifically linked to the achievement of UHC, describes itself as "[c]overage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)."[9]

The legal imperative for prioritizing the health of women and children is found in numerous treaties and in customary international law expressing the right to health as an international legal obligation. Today, 170 of the 194 United Nations member states have ratified the International Covenant on Economic, Social and Cultural Rights, 53 states have ratified the African Charter on Human and Peoples' Rights, and 34 states have ratified the Revised European Social Charter.[10] Each of these instruments protects the right to health and calls for the special protection of women and children.[11]

Additionally, several legal instruments emphasize the legally binding nature of the obligation to prioritize women and children. The express protection of the right to health for women and children is found in articles 11(1)(f), 12, and 14(2)(b) of the Convention on the Elimination of All Forms of Discrimination against Women and in article 24 of the almost universally ratified Convention on the Rights of the Child.[12] The former instrument includes the ability of states to take affirmative action to redress past discrimination against women (art. 4), while the latter instrument demands that states give special protection to children (preamble).

Moreover, the repeated expression of *opinio juris* and practice of prioritizing women and children under international human rights law is also emphasized in the scientific context of primary health care and UHC. The scientific reiterations go back to at least the 1978 International Conference on Primary Health Care and its Alma-Ata Declaration, which includes maternal and child health care as part of the essential elements of primary health care. Most recently, paragraphs 28 (related to nutrition) and 29 (reiterating the general obligation of states to protect women and children in relation to access to health services) adopted by the United Nations General Assembly as the Political Declaration of the High-Level Meeting on Universal Health Coverage express the need to prioritize women and children.[13]

States' legally binding commitments are also reiterated in numerous aspirational instruments. For example, the aforementioned article 25 of the Universal Declaration of Human Rights provides that "[m]otherhood and childhood are entitled to special care and assistance." This aspiration is echoed in the American Declaration of the Rights and Duties of Man.[14] Both the 1924 and 1959 declarations on the rights of children call for their special protection.[15] These declarations express the *opinio juris* of the overwhelming majority of states in favor of their existing legal obligations as described above. Most recently, the Inter-Parliamentary Union, an international organization of parliaments made up of legislators from 173 states and with 11 associate members, adopted a resolution calling for efforts to

achieve UHC to be "consistent with international human rights standards" and to prioritize "essential services for women and children."[16]

There can be little doubt that these expressions of support both for the right to health and for the prioritization of women's and children's health are sufficient evidence of state practice and *opinio juris* to demonstrate that the right to health and the need to prioritize women and children have achieved the status of customary international law. As such, they can both be said to be universally legal binding norms and universally accepted as best practices in the field of public health. In other words, ensuring public health generally and prioritizing women and children in doing so are imperatives for all states.

What's wrong with our current approach to UHC?

Despite the abovementioned unequivocal expressions of the need to prioritize women and children, it is not happening in practice. Decades after we made solemn commitments to primary health care in Alma-Ata, there are signs that our commitment to provide primary health care for women and children is wavering. For example, at the recent commemoration of the Alma-Ata Declaration, the Declaration of Astana adopted at the 2018 Global Conference on Primary Health Care under the auspices of the World Health Organization (WHO) and the United Nations Children's Fund failed to prioritize women's and children's health, instead calling for a commitment to more general objectives related to UHC. Furthermore, the recent World Health Assembly resolution adopted by all WHO member states in preparation for the high-level meeting in New York on UHC does not include any reference to children and only a weak reference to women.[17]

While the goal of UHC is laudable, it is not clear that it is consistent with or an adequate practical expression of the right to health.[18] Undoubtedly, the failure to lay its foundation in a rights-based approach—where primary health care for women and children is central—undermines the very basis on which UHC is predicated. Such an approach to UHC might even be harmful to the health of families because it allows manipulation by a government seeking to control rather than empower its population. It is a step back toward the outdated practice of imposing health care from above, or, even perhaps more harmfully, of providing health care only when it is financially profitable. In fact, there is significant evidence that investing in women's and children's health is the more cost-effective investment that states can make for achieving universal health coverage.[19]

This is an argument not for a vertical approach but for a diagonal one, which Julio Frenk has described as a "strategy in which we use explicit intervention priorities to drive the required improvements into the health systems" and health services.[20] It has been convincingly argued that the prioritization of interventions to protect women's and children's health has produced the most substantial public health benefits for the people in countries where such an approach has been taken.[21]

The current approach to UHC also fails to adequately embrace participation and accountability, two elements that are central to a rights-based approach to health. This is contrary to the desire expressed by governments and nongovernmental actors to make participation more meaningful and to provide for accountability mechanisms. Both the Alma-Ata Declaration (para. VI) and the Astana Declaration (para. IV) call for greater participation. The latter declaration also embraces the idea that greater participation contributes to accountability (para. IV).

The need for accountability, which emerged more recently, is confirmed by efforts to create human rights mechanisms to allow individuals to complain about government failure to protect the right to health. In Africa, Europe, and the Americas, for example, most countries have agreed to allow individuals to challenge their governments when they fail to ensure the right to health. In addition, the United Nations General Assembly's 2017 resolution "Global Health and Foreign Policy: Addressing the Health of the Most Vulnerable for an Inclusive Society," adopted by 152 votes, states that appropriate participation must be safeguarded by

strengthened accountability.[22] Lastly, the first United Nations Special Rapporteur on the right to the highest attainable standard of health, Paul Hunt, has unequivocally stated that "the right to health … demands accountability."[23]

Prioritizing women's and children's health is an imperative, not a political choice

States have expressed that prioritizing women's and children's health is an imperative, not a political choice. This difference is important. When conceptualized as a political choice, health priorities are merely trade cards in a political game of self-interests, where the interests of the rich and powerful often trump those of all others. When conceptualized as an imperative, they are non-negotiable goals that governments must strive to achieve.[24] As an imperative, prioritizing the health of women and children must be the basis of primary health care and therefore essential to the effective implementation of UHC. There are numerous consequences of this recognition.

As the aforementioned legal obligations indicate, achieving the right to health and prioritizing women and children while doing so imposes international legal responsibilities on states. These legal obligations require that states ensure interventions that protect public health and provide special protections for women and children. If states do not meet this responsibility, they may be held accountable by the people under their jurisdiction in both domestic and international forums. Already, countries such as South Africa and India have imposed significant obligations on states in relation to the right to health and specifically in relation to women's and children's health.[25] While such accountability mechanisms are still underdeveloped, it is rational to believe that they will continue to develop.

Setting the health of women and children as a public health priority also makes economic sense. Investing in prioritizing interventions to promote and protect women's and children's health is the "best buy" a state can make in its public health.[26] This is a significant concern for states trying to stretch limited resources to fast-growing populations.

Protecting women and children is also logical because states' health indicators virtually always begins with maternal, infant, and child mortality. The truth of this statement was demonstrated in 2015, when states adopted these indicators as the primary point of reference for SDG 3.[27] Interventions that show progress in these indicators not only improve public health but also do so in measurable and apparent ways. Such observable advances in public health are both politically valuable and useful for comparative measurement, which, in turn, as stated by former WHO director-general Margaret Chan, means that "[w]hat gets measured get done."[28]

Achieving the prioritization of women's and children's health as an imperative is also enhanced by cooperation between the Office of the United Nations High Commissioner for Human Rights (OHCHR) and WHO. Professor Gillian MacNaughton has chronicled this cooperation.[29] She notes that in 2015, the OHCHR collaborated with WHO and the United Nations Population Fund to produce technical guidelines for policy makers seeking to implement a human rights-based approach to maternal and child health.[30]

A year later, the OHCHR and WHO collaborated to establish the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents and on the development and adoption of the United Nations Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health for 2016–2030.[31] The high-level working group recommended that WHO and OHCHR collaborate even more closely on health and human rights.[32]

In November 2017, WHO and the OHCHR agreed to the WHO-OHCHR Framework of Cooperation committing each entity to cooperate on the right to health in general terms. The agreement, which is not in the public domain, does not call for measurable results or provide for accountability. Nevertheless, it evidences the general willingness of these important actors to continue to work toward fulfillment of the right to health. If implemented in good faith—in a participatory manner with an effective accountability mechanism—this agreement

could be an important step toward ensuring the prioritization of women and children in countries and in global UHC strategies.

The prioritization of women's and children's and health makes good sense both legally and scientifically. States have expressed the will to do this in United Nations forums. It is hoped that WHO's laudable effort to achieve UHC will keep pace with these expressions of commitment to women's and children's health. These are two of the most important groups of people whose health, when adequately prioritized, reflects most significantly on the health of us all. As one of the leading proponents of UHC has noted, putting "women and children first [is] an appropriate first step towards universal coverage."[33]

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