

The inclusion of sexual and reproductive health services within universal health care through intentional design

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Abstract: *In this paper, we argue that how sexual and reproductive health (SRH) services are included in UHC and health financing matters, and that this has implications for universality and equity. This is a matter of rights, given the differential health risks that women face, including unwanted pregnancy. How traditional vertical SRH services are compensated under UHC also matters and should balance incentives for efficiency with incentives for appropriate provision using the rights-based approach to user-centred care so that risks of sub-optimal outcomes are mitigated. This suggests that as UHC benefits packages are designed, there is need for the SRH community to advocate for more than simple “SRH inclusion”. This paper describes a practical approach to integrate quality of SRH care within the UHC agenda using a framework called the “5Ps”. The framework emphasises a “systems” and “design” lens as important steps to quality. The framework can be applied at different scales, from the health system to the individual user level. It also pays attention to how financing and resource policies intended to promote UHC may support or undermine the respect, protection and fulfilment of SRH and rights. The framework was originally developed with a specific emphasis on quality provision of family planning. In this paper, we have extended it to cover other SRH services. DOI: 10.1080/26410397.2020.1799589*

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Introduction

Momentum is building within the sexual and reproductive health and rights (SRHR) community that SRHR be considered a core component of Universal Health Coverage (UHC). Discussions on how to integrate SRHR within UHC are ongoing, spurred on by two momentous events in 2019: the political declaration of many countries to recommit to achieving UHC by 2030 at the 74th United Nations General Assembly, and the Nairobi Summit on ICPD25 to commemorate the paradigm-shifting Cairo Plan of Action.¹ SRHR and UHC are inter-linked concepts and, since progress toward one supports the other, a mutually reinforcing approach can achieve the goals of both initiatives.

In this paper, we argue that while driving to ensure SRHR is included within UHC, it is important not to lose focus on the quality of care provided to health system users. Furthermore, we argue that a comprehensive set of sexual and reproductive health (SRH) services under UHC be progressively

implemented, since not all services will necessarily be immediately available in all programme settings.

Paying attention to quality is important for two reasons. First and foremost, providing quality care is a fundamental right that health care consumers should be guaranteed. Second, a singular focus on increasing coverage without a concomitant focus on measuring and managing quality will not deliver the intended health impact.^{2,3} Illustrative of this point is the experience from India of improving coverage of maternal health services. A conditional cash transfer programme was implemented across nine states to improve institutional deliveries by removing financial barriers.⁴ Although institutional births increased significantly, there was no significant association with maternal mortality. Examples such as these could be the reason why the 2018 Lancet Global Health Commission noted that “providing health services without guaranteeing a minimum level of quality

is ineffective, wasteful, and unethical”.⁵ Furthermore, the Lancet Global Health Commission called for “progress on UHC to be measured through effective or quality-corrected coverage”. In other words, it reiterated the importance of measuring, monitoring, and managing the quality of care produced in any health system.

ICPD25 called for adoption of a comprehensive package of SRHR as proposed by the Guttmacher-Lancet Commission,⁶ that encompasses the range of services that a person would need as they go through their reproductive lifecycle. A comprehensive package would include: counselling and services for contraceptives; safe abortion services and treatment of unsafe abortion; antenatal, child-birth and postnatal care; counselling and services for infertility; prevention and treatment of HIV and other STIs; counselling services for sexual health and wellbeing; comprehensive sexuality education (CSE); detecting, preventing and managing reproductive cancers; and detecting and preventing sexual and gender-based violence.

A number of countries have included selected SRH services within UHC. The service areas are often those that have traditionally been considered the core of SRH programming, such as maternal and child health (MCH) services and family planning. Within the MCH cluster of services, focus has tended to be on antenatal, delivery and postnatal care, and less on newborn care. For example, the Linda Mama free maternity scheme in Kenya offers free maternity services in addition to antenatal and postnatal care, inclusive of post-partum family planning. Some countries have begun to include family planning within UHC initiatives that address financial barriers; for example, Ghana is experimenting with the inclusion of family planning in the national health insurance benefits package. It is unclear as to the extent to which other SRH service elements such as safe abortion, treatment of unsafe abortion or CSE, and newer SRH service areas such as reproductive cancers and infertility, are included. Irrespective of the SRH service area, the focus of programming has tended to be on inclusion of the service area into the benefits package and less on the quality of care to be provided. It has been implicitly assumed that good quality care will result from inclusion in benefits packages provided by accredited in-network facilities. Finally, we recognise that policy and programme intentions to deliver good quality care may not be feasible without sufficient financing to back the initiative. As noted by

advocates, political commitment to financing quality SRH services is essential.

This paper describes a practical approach to integrating quality of SRH care within the UHC agenda. It proposes a framework called the “5Ps” for ensuring that quality is built into UHC. The framework emphasises a “systems” and “design” lens as important steps to quality. The framework can be applied at different scales, from the health system to the individual user level. It also pays attention to how financing and resource policies intended to promote UHC may support or undermine the respect, protection and fulfilment of SRHR.

Methods

To assess the practical alignment of financing of quality SRH services under UHC, we undertook a mapping review of the literature to trace evolving notions of SRH quality that have led to the framework we propose in this paper. The initial search focused on foundational papers conceptualising quality in family planning services^{7,8} and, for elaboration of the concept of SRHR, global policy documents such as the ICPD plan of action, ICPD+25, and the Guttmacher-Lancet Commission report.^{1,6} Subsequent papers were identified based on citation patterns and expert consultation. The findings from the mapping review were synthesised and subsequently informed the creation of the framework in this paper.

Findings

5Ps framework

How SRH services are included in UHC and health financing matters. Adequate financing has implications for universality and quality. This is a matter of rights, given the differential health risks and needs that women face, including unwanted pregnancy. How traditional vertical SRH services, like family planning, are compensated under UHC also matters and should balance incentives for efficiency with incentives for appropriate provision using the rights-based approach to user-centred care so that risks of sub-optimal outcomes are mitigated. This suggests that as UHC benefits packages are designed, there is need for the SRH community to advocate for more than simple “SRH inclusion”. While our paper has focused on basic benefits packages within national health insurance and in

mixed health systems, we acknowledge that other approaches to UHC exist. Our focus is also on the strategic purchasing component of health financing and not on the risk-pooling or revenue generation components.

An organising framework is proposed that addresses:

- People: for whom to purchase
- Package: what to purchase
- Provider: from whom to purchase
- Payment: how to purchase
- Polity: why purchase

The framework was originally developed with a specific emphasis on the quality provision of family planning.^{9,10} In this paper, we have extended it to cover other SRH services. Following the framework (Table 1), we describe how the different elements of purchasing may influence quality of SRH care.

People: for whom to purchase

Progress toward UHC is intended to remove financial barriers to quality health services. However, SRH financial barriers for women and girls may not be recognised or prioritised within UHC schemes, even by the SRH community, given other supply- and demand-side barriers.¹¹ It is estimated that out-of-pocket (OOP) payments comprise nearly half (49%) of the costs of reproductive, maternal, neonatal and children's healthcare¹¹ and will account for most of the financing for family planning products over the next three years;¹² estimates are not available for other SRH products. Financing through OOP for family planning and other SRH services may not be viewed as catastrophic or a financial hardship for women and girls, but may result in unplanned pregnancy and recourse to unsafe abortion, with potentially catastrophic consequences for the individual and her family. Furthermore, the health system will bear costs due to the management of mistimed or unintended pregnancies. The existence of financial barriers means that negative SRH outcomes will fall disproportionately on the poor and socially marginalised.

SRH choice may also reflect constraints imposed by price rather than individual preference. There are examples from family planning about how decisions to seek services, from whom, and what methods to use are influenced by price constraints. A study by Ugaz et al¹³

found that, in 17 of 30 countries, a greater proportion of poorer women used short-acting methods over long-acting methods than wealthier women, suggesting that financial barriers may suppress choice. Cost may deter adolescents altogether from accessing SRH services, more than it does adults. This may be due to their limited capacity to access services independently from their parents, and their limited access to cash, either their own or that of their family.¹⁴ The WHO global consultation on adolescents indicated that very few (6%) adolescents pay OOP for health services and many (45%) report that their parents and/or family members were the principal payers of their healthcare costs,¹⁵ which are unlikely to include family planning or other SRH services. When financial barriers are removed, an individual may be able to act upon their preference to both seek and choose a family planning method or other SRH service. However, it is recognised that other barriers may exist and intersect with financial ones.

While the current focus of SRH policies and programmes on girls and women is warranted, concomitantly it will be important to design SRH services for under-served populations, such as women nearing the end of their reproductive lifecycle, and boys and men as an aspirational intent. Women's reproductive health needs beyond family planning and MCH care have largely been ignored, and a comprehensive SRH paradigm as indicated by the Guttmacher-Lancet Commission report provides guidance on areas such as infertility and reproductive cancers. Similarly, boys and men have not been viewed as users of health systems but as levers to improve the SRH of their sisters or their partners.

Finally, ensuring a voice for the people served by the health system is essential so that they can express their needs, priorities, and demand accountability for good quality services. Users need to be assured of their rights to good quality SRH care. We know from women's accounts, and observations of care during childbirth and immediately thereafter indicate, that women are often treated poorly and with little respect. A four-country study reported that a third of women delivering in health facilities were mistreated.¹⁶ Younger and less educated women were more likely to be mistreated than others, indicating the importance of ensuring a voice for the more marginalised of health system users.

| Table 1. 5P framework | | |
|--|--|---|
| Purchasing domains | Purchasing elements | SRH considerations |
| People: <i>For whom to purchase</i> | <ul style="list-style-type: none"> • Defined target clientele • Clientele awareness • Community and society engagement | <ul style="list-style-type: none"> • Unmet need • Equity (e.g. poor women and men, adolescents) • Client adherence (e.g. FP, ART medication) • Financial barriers/ out-of-pocket expenditure |
| Package: <i>What to purchase</i> | <ul style="list-style-type: none"> • Defined benefit objectives • Defined benefit package | <ul style="list-style-type: none"> • Broad contraceptive options to improve choice, enable switching, and reduce discontinuation • SRH integration into RMNCAH continuum/packages • Benefits beyond health outcomes (e.g. autonomy, economic participation) |
| Provider: <i>From whom to purchase</i> | <ul style="list-style-type: none"> • Contracting • Accreditation • Integration (e.g. of public and private providers; of relevant services) | <ul style="list-style-type: none"> • Physical access/choice of outlet • Minimum quality standards • Integration of the private sector including digital support • Client realisation of rights to services and quality |
| Payment: <i>How to purchase</i> | <ul style="list-style-type: none"> • Payment rates • Payment methods • Provider autonomy • Claims processing • Quality assurance (data and clinical) | <ul style="list-style-type: none"> • Likelihood of being offered an SRH service, or choice of service (e.g. choice of FP method, choice of uterine evacuation) • Efficiency and quality • Regulatory and public financial management |
| Polities: <i>Why purchase (rationale and institutional arrangements)</i> | <ul style="list-style-type: none"> • Political commitment • Institutional arrangements • Purchaser alignment (across mechanisms) • Monitoring and accountability • Performance management | <ul style="list-style-type: none"> • Societal benefits (SRHR, gender equality, public health impact) • Economic benefits (women's participation in the labour force and demographic dividend) • Normative environment and ability to realise SRH rights • Stewardship and ownership (e.g. government and donors, central and decentralised) • Fragmentation and adequacy of financing (horizontal and vertical coherence) • Regulatory and legal environment (e.g. safe abortion) |

Package: what to purchase

What to purchase has implications for choice and an appropriate constellation of SRH services. While governments often prioritise essential health services in benefits packages, this does not always include SRH services. This is the case even with services such as family planning. Research by Eldridge and Appleford¹⁷ found that only six of 14 government-sponsored health insurance schemes in USAID family planning priority countries included family planning in their benefit package (no information was provided on constellations of SRH services). Service exemption schemes for MCH, such as those in Sahelian countries, may also fail to include family planning as part of a continuum of care.^{10,18} Even when family planning is included in a benefits package or service exemption scheme, this may not translate to provision. A seven-country study of health insurance schemes¹⁹ concluded that despite the formal inclusion of family planning services in the national benefits packages examined, actual integration of these services faced challenges, with implications for the availability of family planning services in practice. A study in India also found that use of family planning under the national health insurance scheme was low, estimated at 2%, with poorer families less likely to know of its inclusion.²⁰

The SRH community may conflate SRH inclusion in benefits packages with choice. However, this may not account for user preference in specific types of outlets or differential requirements for different services. For example, for family planning, non-clinical outlets, such as pharmacies or shops, may be preferred by some users, who desire methods such as condoms and emergency contraception that do not require visiting a medical facility²¹ and prefer a more anonymous, less interpersonal transaction. Long-acting reversible contraception (LARCs) on the other hand may benefit from explicit inclusion in a benefits package, given that these methods require a clinical setting and have additional competency and consumable requirements for their delivery. These differences may not be reflected within the global SRHR community, which may advocate for equal treatment of all family planning methods within benefits packages, without a more nuanced view of requirements. Similarly, CSE, although an essential health promotive intervention, may not need to be included in a health benefits package. CSE could be offered through alternative means including social media and non-health

sectors such as education and youth and development.

We recognise that multi-sectoral approaches will be required to provide services such as CSE through both the health and education sectors. In this way, the needs of adolescents who are both in and out of school can be met. While evidence of how to deliver CSE and demonstrate its effectiveness is increasing, it is less clear whether it will be covered under UHC.²²

We acknowledge that the full gamut of SRH services do not receive the same emphasis in UHC schemes; for example, it has been noted that maternal health and family planning have received greater emphasis than other SRH areas such as safe abortion and sexual and gender-based violence.²³ It is possible to rationalise the emphasis on family planning in that it can obviate some of the need for safe abortion services by preventing pregnancies. However, with progressive realisation of UHC, the aspiration is that all components of SRH services will be covered.

Payment: how to purchase

How SRH services are purchased within UHC schemes has implications for whether services are provided and how well they are provided. Service quality may be readily and routinely observable, such as technical competence of health care providers and implementation of follow up or continuity mechanisms, as well as less observable but no less meaningful quality measures such as interactions related to information given to users and interpersonal relations. Strategic purchasing is seen as the mechanism through which UHC objectives can be met.²³ More importantly, strategic purchasing is a mechanism for ensuring quality of services as coverage improves, and for ensuring accountability to users and communities.

In family planning, for instance, we know that payment mechanisms can influence the extent to which individuals genuinely choose the family planning method of their choice.²⁴ For example, in Kenya, family planning is included under capitation for short-term and long-acting methods and under fee-for-service for permanent methods within the National Hospital Insurance Fund (NHIF). The NHIF is implemented in public facilities where line item budgets cater for family planning inputs such as health worker time and commodities and in private facilities where there is no budget support. The combination and form of payment may induce different provider behaviour

and result in improved access to SRH services and increase service quality. Vouchers can help women to exercise their SRH rights including to quality, informed choice, and accessible services.²⁵ In Kenya, a pilot programme offered a voucher reimbursing medical, legal, and psycho-social support services for sexual and gender-based violence recovery aimed to improve the offer and continuity of care.²⁶

The importance of the type of financing mechanism and the care provided has been noted for maternity care as well. For example, in Kenya, evidence suggests that the initiation of antenatal care and continued use of maternal services is influenced by the type of financing.²⁷ Women who had private insurance or had vouchers for maternity care were likely to continue to use maternity services, indicating that they valued (and could afford) the service they received.

These examples illustrate that, increasingly, LMICs are experimenting with different payment approaches and may blend two or more payment mechanisms. Sources of SRH service purchasing may include:

- Commodity procurement through a centralised government body using domestic and/or donor financing.
- Purchasing of healthcare services, from public health facilities through line-item budgets. This is often referred to as passive purchasing as national governments may allocate budgets based largely on funding received the previous year.
- Purchasing of SRH services from public and private health facilities through national health insurance on behalf of registered members or entitlement schemes, such as free maternity care. Often this form of purchasing is referred to as strategic, or more active purchasing, as it is based on some form of output, such as the number of deliveries attended or other health-related outcomes.
- Results-based financing (RBF) often entails financing from donors (such as the World Bank and the GFF), channelled through the Ministry of Finance to purchase or incentivise services mainly from public health facilities, but may also include the private sector. In these schemes, SRH services such as family planning are generally included as one of several RMNCAH priority services, while others may be omitted altogether. Reimbursements are based

on results in the form of incentives for reported outputs and quality indicators. RBF relies upon other inputs such as commodities, staff and infrastructure being paid through other mechanisms.²⁸

The array of financing options serves to illustrate that a narrow focus on commodities or line item budgets may miss other potential sources of SRH purchasing. These may be more important over time, particularly if they are positioned as the main vehicles for UHC, as in the case of national health insurance in many contexts. Lessons emerging from Mexico and Thailand suggest that progress towards UHC in terms of developing effective financing mechanisms needs to be accompanied by attention to services which predominantly affect women, such as SRH, and efforts to tackle the underlying political and social determinants that undermine access for vulnerable and marginalised groups, such as poor women and adolescents.²⁹ Where family planning and other SRH services have been effectively included in national health insurance schemes, this has been associated with improved access to and uptake of modern family planning methods, as demonstrated in the Latin America and Caribbean region.³⁰

In reality, mixed healthcare financing systems like those in Malaysia and Botswana underscore the importance of framing SRH financing, beyond a narrow focus on national health insurance, as part of the larger drive to UHC.^{31,32}

Provider: from whom to purchase

“Healthy competition” through client choice of provider is also an important aspect of quality. This may allow women and couples to select providers that have higher client perceptions of quality, such as short waiting times or more informative and interpersonal interactions with clients. According to a recent study, the private sector provides 37% of family planning services globally, making a significant contribution to access; of this share, over half (54%) of family planning services are provided by medical providers, 36% by specialised drug sellers, and 6% by retailers.²⁴ Women also select providers based on OOP cost; clients may choose a private provider for short-term methods that are more affordable but seek more expensive methods such as LARC from public providers, where the service may be free or nearly free for the consumer.¹³

Considering that adolescents are a special population, advocates have provided practical guidance on how adolescents' SRHR needs can be met within UHC²² and in particular, suggestions for including other points of care that adolescents might prefer, such as pharmacies, in strategic purchasing schemes. We also know that due to the advancements in R&D and availability of health technologies, self-care in many areas of SRH is an emerging and feasible possibility. For example, women can initiate/complete a safe abortion procedure with medical abortion drugs; self-administer Sayana Press or use vaginal rings for contraceptive protection; self-test for HIV; and use misoprostol as a prophylaxis against postpartum haemorrhage at the time of delivery at home. The possibility of self-care has enlarged the pool of health care providers to include community-based health workers, patent medical vendors and chemists, online consultation, e-pharmacies, and digital health advice platforms. Evidence on the financing of self-care is limited. Caution must be taken to avoid equating self-care with self-financed care, e.g. care in the absence of public subsidy and private sector financing.³³

Polity: why purchase

The 5th P, polity, considers the rationale and institutional arrangements for purchasing SRH services. Service quality should inform resource allocation decisions and strategic purchasing arrangements. This should be supported by available data and evidence recognising that some process quality elements, such as interpersonal care and client experience, are difficult to routinely measure in the absence of consumer digital platforms (unlike in other consumer marketplaces such as transport – Uber, or eateries – Yelp), and thwart quality measurement in UHC and speak to the absence of a user-centred health ecosystem more broadly. Given this, effort may be better placed on a normative environment for quality and rights evidenced through political commitment, national stewardship and ownership of SRH programmes. Situating SRH service quality within broader efforts to achieve and measure effective coverage of UHC is recommended.

Discussion

The SRH community should advocate for service “quality by design” within purchasing strategies.

This would shift attention to the design of purchasing strategies and their effects on SRH process elements. At present, quality is often addressed as service units in SRH quality frameworks, and may benefit from a broader systems lens. Quality by design could include use of purchasing metrics that reduce risk of missed opportunities and promote the inclusion of quality within a constellation of care. For example, family planning could be rewarded within antenatal and postnatal care as part of a quality modifier to performance-based financing schemes. Other illustrations include integrating HIV prevention and management into maternal health, family planning, and mental health; or integrating gender-based violence screening with safe abortion services. Such integration would better align with UHC quality and health systems objectives of integrated people-centred care.³⁴

The SRH community should ensure that purchasing strategies support a client-oriented, rights-based approach to high quality services. The quality of SRH services is determined by measuring service inputs, processes and outcomes. SRH purchasing strategies may incentivise high quality, but still fail to strengthen a rights-based approach. Implementing SRH purchasing strategies from a rights-based perspective asks which policies will help to make SRH services universally accessible, acceptable, and available. Regardless of the purchasing strategy selected in a given context, the SRH community of practice has an obligation to ensure that the purchasing strategy supports a rights-based approach to high quality SRH services.

Ideally, there would be more “active” strategic purchasing for SRH services, drawing from a range of financing mechanisms, with effort taken to ensure that these operate coherently. This is the premise of strategic purchasing, defined as the “continuous search for the best ways to maximize health system performance by deciding which interventions should be purchased, how, and from whom”.³⁵ The process (“how”) or mechanisms (“what”) through which payments for specific SRH services are made can be an important determinant of whether and how well SRH services are provided.³⁶ In the case of family planning, research shows that contraceptive discontinuation decreases, and contraceptive use increases, with improved quality of care.^{37,38} “Who” these payments are made to matters equally. In the case of the

public sector, payment may not make its way to the health facilities delivering the services, further constraining whether and how well services are provided. The private sector may also be excluded. Considerations such as these are critical to family planning given that, according to two datasets published in 2017, contraceptive discontinuation accounted for about 38% of women with unmet need and accounted for about 35% of unintended pregnancies.³⁸

Conclusion

Our opinion is that the 5Ps framework provides guidance on the range of potential actions that each type of stakeholder can take: policy maker (from both the ministries of health and of finance), programme designer, provider, advocate and user. It provides policy makers with insight on both the technical components and political calculations that will feed into their decisions. Programme designers can draw upon ideas as they intentionally include quality in the formulation and planning of SRH services. Providers in both the public and private sectors can identify where and how they wish to engage in SRH service delivery. Advocates can become conversant with the concept of quality by design, adopt language that will be understood by a wide swathe of stakeholders, and identify entry points for advocacy engagement. Users are aware of the range of SRH services that they can access from various providers and the price they have to pay, if any.

The Guttmacher-Lancet report has laid out an aspirational set of SRH services to take forward from the twenty-fifth anniversary of the ICPD Plan of Action. The 1990 Bruce framework's definition of quality included a constellation of integrated SRH services that a user of a health system might need.⁷ Our opinion is that this perspective of integrated SRH services not only reflects good quality but also demonstrates how a rights-based client-centred approach can be implemented. Calls for integrated SRH services have articulated a three-pronged strategy: engaging and empowering local communities; securing leadership, governance and financing; and coordination of activities within the health and across other sectors.³⁹

The 5Ps framework provides a practical approach to take into account the role of strategic purchasing to address quality and, if

anchored to UHC, to implicitly address equity as well. Equitable access to integrated, comprehensive care is more likely in UHC-style systems, which enable policymakers and health planners to rationalise service delivery. The framework allows for considerations such as gender equity, especially, as related to women's access to services such as cancer care that have high OOP costs. It also provides a way to rationalise the expansion of SRH services beyond family planning, MCH and HIV care to include breast and cervical cancer.

In conclusion, the field can draw upon the experience and successes of countries such as Thailand and Mexico which have included SRHR within UHC.^{40,41} Furthermore, they demonstrate how coverage of newer SRH areas can be included. Thailand was able to demonstrate better health outcomes, higher utilisation of SRH services and improved equity of access. A key factor in Thailand's success was the inclusion of a comprehensive package of SRH services including treatment of reproductive tract cancers in the UHC benefits package. Additionally, lessons emerging from Thailand highlight the importance of improving access of youth to essential family planning and safe abortion services, and CSE to redress unintended pregnancy among girls and violence against women. Thailand was able to achieve its successes due to an approach of incrementally adding to the package of services along with a financing mechanism that targeted specific populations. The experience of the national public health insurance programme (*Seguro Popular*) from Mexico demonstrates how health coverage can be expanded to include cervical screening and mammography as well their treatment.⁴¹

Just as the Cairo Conference heralded a new paradigm of reproductive health, we anticipate that integrated good quality SRH care will be a reality in the decade to come.

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Résumé

Dans cet article, nous avançons que la manière dont les services de santé sexuelle et reproductive (SSR) sont inclus dans la CSU et le financement de la santé a de l'importance et qu'elle a des conséquences sur l'universalité et l'équité. C'est une question de droits, étant donné les risques différentiels que courent les femmes, notamment les grossesses non désirées. La façon dont les services de SSR verticaux traditionnels font l'objet d'une compensation au titre de la CSU compte aussi; à cet égard, il faudrait équilibrer les mesures qui stimulent l'efficacité avec les mesures qui encouragent une prestation de services adaptée en adoptant une approche fondée sur les droits pour des soins axés sur l'utilisateur, afin d'atténuer les risques de résultats sous-optimaux. Cela donne à penser que lors de la conception des paniers d'avantages de la CSU, la communauté de la santé sexuelle et reproductive doit plaider pour davantage qu'une simple « inclusion de la SSR ».

Resumen

En este artículo, argumentamos que importa la manera en que los servicios de salud sexual y reproductiva (SSR) son incluidos en la cobertura universal de salud (CUS) y en el financiamiento de salud, y que esto tiene implicaciones para la universalidad y equidad. Es cuestión de derechos, en vista de los riesgos diferenciales para la salud que enfrentan las mujeres, tales como embarazo no deseado. También importa la manera en que los servicios de SSR verticales tradicionales son compensados bajo la CUS y se debe equilibrar los incentivos para eficiencia con incentivos para la prestación de servicios correspondientes, utilizando el enfoque basado en los derechos de atención centrada en los usuarios, con el fin de mitigar los riesgos de resultados subóptimos. Esto indica que a medida que se diseñan los paquetes de beneficios de CUS, existe la necesidad de que la comunidad de SSR abogue por más que una simple

Cet article décrit une approche pratique d'intégration de la qualité des soins de SSR dans le programme de la CSU à l'aide d'un cadre de travail appelé les « 5 P ». Le cadre met l'accent sur une optique de « systèmes » et de « conception » comme mesures importantes pour la qualité. Le cadre peut être appliqué à différentes échelles, depuis le niveau du système de santé à celui de l'utilisateur individuel. Il accorde aussi une attention à la manière dont les politiques de financement et de ressources destinées à promouvoir la CSU peuvent soutenir ou saper le respect, la protection et la réalisation de la santé et des droits sexuels et reproductifs. Ce cadre a été initialement élaboré dans la perspective spécifique des services de planification familiale de qualité. Dans cet article, nous l'avons étendu pour couvrir d'autres services de SSR.

“inclusión de SSR”. Este artículo describe un enfoque práctico para integrar la calidad de los servicios de SSR dentro de la agenda de CUS utilizando el marco conocido como las “5P”. El marco hace hincapié en una perspectiva de “sistemas” y “diseño” como pasos importantes para la calidad. El marco puede aplicarse en diferentes escalas, desde el sistema de salud hasta cada usuario. Además, presta atención a cómo las políticas de financiamiento y recursos destinadas a promover la CUS podrían apoyar o socavar el respeto, la protección y el cumplimiento de la SSR y los derechos relacionados. El marco fue creado con particular énfasis en la prestación de servicios de planificación familiar de calidad. En este artículo, lo hemos extendido para abarcar otros servicios de SSR.