An Intersectional Feminist Approach for Advancing Sexual and Reproductive Health and Rights Through Universal Health Coverage

Mandira Paul, Karolinska Institutet, Rajalakshmi RamPrakash, Independent Consultant, Veloshnee Govender, WHO, , and Jesper Sundewall, University of KwaZulu-Natal

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Summary

It is broadly agreed that sexual and reproductive health and rights (SRHR) and universal health coverage (UHC) are intimately linked. UHC has been described as a pragmatic means for advancing SRHR, and SRHR is considered an essential component of UHC. SRHR is universally recognized as a fundamental dimension of health and well-being and a human right. Ensuring SRHR requires a comprehensive, intersectional, and life-course approach, recognizing the layers of privilege or vulnerability that may influence one's sexual and reproductive health needs and opportunities to fulfill one's sexual and reproductive rights, as well as the shifting needs of individuals across the life course. UHC, on the other hand, implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative, and palliative essential health services. UHC also entails access to quality medicines and vaccines while ensuring that the use of these services does not expose the users to financial hardship. In 2019, the Political Declaration on UHC stipulated that access to SRH services as a key aspect of UHC was to be achieved by 2030. The declaration also reaffirmed commitments to the International Conference on Population and Development Programme of Action and Beijing Platform for Action. While SRHR is integral to the UHC agenda, and the delivery of both SRH services and UHC relies on functioning and quality primary health care systems, there are limitations of the UHC agenda for advancing SRHR.

The aspiration of UHC and to what extent it has integrated SRHR under its ambit and advanced it from a gender and rights perspective can be revealed by a set of cases reflecting the experiences of people in vulnerable situations, which illustrate different shortcomings in the current UHC framework and its translation on the ground. These shortcomings include systematic exclusions and discrimination of persons currently belonging to marginalized groups, inadequate investment in and respect for women health workers, violations of autonomy and dignity, lack of accountability, and power of politics. These shortcomings, which limit access to and experience of quality health services, cannot be removed by narrowly focusing on addressing the "ability to pay" or reducing the financial barriers alone. Therefore, the current framing of UHC is insufficient to progressively realize SRHR and thus demands a reconceptualization and/or extension of current framing and design.

To address the shortcomings, an intersectional feminist approach to UHC is proposed. Shifting mindsets and including gender and power analysis in UHC design, operationalization, and measurement of UHC outcomes will allow for achieving the UHC objectives of financial protection, equity in access, and service quality. Taking an intersectional feminist approach to UHC would improve not only SRHR outcomes but also health outcomes at large. It will furthermore offer a pathway to truly deliver on the objectives of UHC—equitable health care for all.

Keywords: universal health coverage, sexual and reproductive health and rights, intersectional feminism, gender, rights, equity, access, quality

Subjects: Sexual and Reproductive Health

Introduction

Sexual and reproductive health and rights (SRHR) is universally recognized as a fundamental dimension of health and well-being and a human right (International Conference on Population and Development, 1994). SRHR encompasses physical, emotional, and social aspects of human sexuality and reproduction. In a similar way, universal health coverage (UHC) is considered a cornerstone for ensuring the right to health, a precondition for human well-being and sustainable development. Both UHC and SRHR rely to a large extent on a well-resourced and functioning primary health care (PHC) systems.

Ensuring SRHR requires a comprehensive, intersectional, and life-course approach. This also entails recognizing the layers of privilege or vulnerability that may influence one's sexual and reproductive health (SRH) needs and opportunities to fulfill one's sexual and reproductive rights and the shifting needs of individuals across the life course. The Guttmacher–Lancet commission (Starrs et al., 2018) provided a comprehensive definition of SRHR alongside nine essential interventions. SRHR extends beyond mere health care provision, emphasizing the fundamental rights of individuals to make informed decisions about their own bodies, free from discrimination and coercion. SRHR is critical for improving health and gender equality, as well as ensuring human rights and economic and social well-being, and it is a prerequisite for development and achieving the Sustainable Development Goals.

UHC implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative, rehabilitative, and palliative essential health services, as well as quality medicines and vaccines, while ensuring that the use of these services does not expose the users to financial hardship. UHC places a special emphasis on people living in poverty, those in vulnerable situations, and marginalized segments of the population (United Nations, 2023b).

It is broadly agreed that SRHR and UHC are intimately linked. UHC has been described as a pragmatic means for advancing SRHR, and SRHR is considered an essential component of UHC (United Nations Population Fund [UNFPA], 2019). SRHR thus must be achieved if UHC goals are to be attained. There is increasing recognition of health as a human right alongside the state's responsibility for ensuring access to essential health services for the entire population (Hagos et al., 2023; Sundewall & Poku, 2018). SRHR is included in the UHC 2023 Political Declaration (United Nations, 2023a) in paragraph 62,[1] and aspects of SRHR are reflected throughout the declaration, such as maternal and child health, prevention and treatment of HIV and AIDS and other sexually transmitted infections, and protection of health workers from sexual- and gender-based violence. Comprehensive SRHR services should be progressively included in UHC, paying special attention to people living in poverty and populations in vulnerable situations (Starrs et al., 2018; World Health Organization [WHO], 2022b). The United Nations sexual and reproductive health agency, UNFPA, has described SRHR as an essential element of UHC, as well as an enabler to reap the benefits of the demographic dividend in countries with young populations. In their

report (UNFPA, 2019), UNFPA emphasized the importance of a life-course approach, grounded in equity in access, quality of care, and accountability. A review of how SRHR is included in health benefits packages in low- and lower-middle-income countries also showed that many SRHR services are reflected when countries prioritize health services (Partnership for Maternal Newborn and Child Health, 2019). However, most countries are still lacking explicit commitments to SRHR, and services such as abortion and contraception remain absent in health benefits packages (Hepburn et al., 2021; Ravindran & Govender, 2020). Data show that almost everyone of reproductive age globally—some 4.3 billion people—will lack at least one essential sexual or reproductive health service over the course of their reproductive years. This, despite the relatively low cost of an estimated US$9 per capita annually in low- and middle income countries (LMICs) that would cover the costs of fully meeting the needs for the provision of health services recommended by the World Health Organization to all pregnant persons (including those who experience miscarriages, stillbirths, abortions, or live births) and to newborns, as well as meeting women's needs for modern contraception (Starrs et al., 2018).

While SRHR has a natural place in a UHC agenda, and the delivery of both SRH services and UHC relies on functioning and quality PHC systems, limitations of the UHC agenda for advancing SRHR have been identified. Fried et al. (2013) argued that while UHC is a central means to broader health and development goals, it is not sufficient for universal access to sexual and reproductive health and certainly not for sexual and reproductive rights. Others have highlighted that in addition to arguing for the inclusion of universal access to SRHR in UHC, it is also important to consider how these services are financed in UHC schemes (Appleford et al., 2020). Reviews of SRH service inclusion in health benefits packages also revealed that some essential SRH services, particularly accessing comprehensive abortion care; preventing and treating reproductive cancers, infertility, and subfertility; stopping sexual- and gender-based violence; and providing counseling for sexual health and well-being, are either omitted or poorly available (Hagos et al., 2023; Hepburn et al., 2021; Ravindran & Govender, 2020). Inadequate international and domestic public funding of SRH services contributes to a sustained burden of out-of-pocket expenditure and inequities in access to SRHR (Ravindran & Govender, 2020). Also, while international funding has contributed to positive SRH service outcomes, the levels of funding are far from sufficient to reach global SRHR targets (Ekman et al., 2023). The political nature of UHC makes it vulnerable to political shifts, and conservative groups have increasingly influenced negotiation and design processes at the global, regional, and national levels. There has been increasing debate about the inclusion of SRHR language in negotiations at the United Nations, and SRH(R) has been dropped in key documents and processes to pass resolutions. Gilby and Koivusalo (2020) argue that

> there is a risk that political declarations and commitments which do not focus solely on SRHR, such as UHC, could become a means to establish new language which is silent on SRHR, as governments do not want to undermine the broader commitments to UHC. (p. 3)

Access to and delivery of quality SRHR are adversely affected by several and intersecting challenges. These include pushback from global, regional, and national religious and conservative groups with increasing political influence that are leading an anti-rights and anti-gender agenda. This influence, in combination with policy and legal barriers, inadequate political will, and

systems built on and governed by patriarchal norms and values, has a severe impact on the delivery of SRHR and often targets people living in vulnerable situations. In addition, lack of accurate and verifiable data, including that which is disaggregated by gender, age, and other markers of equity, constitutes major challenges to informed policymaking, service delivery, and equitable access to quality SRH services (Hagos et al., 2023; Ravindran & Govender, 2020).

The aim of this article is to revisit and review the aspiration of SRHR integration into UHC. The progress made as both the UHC and SRHR agenda evolve needs to have a more in-depth understanding. To do this, the UHC commitment is revisited, unpacking how it has unfolded in recent years, not least in light of the 2023 United Nations High-Level meeting. Furthermore, how and to what extent UHC encompasses a gender and rights perspective is discussed, which is critical for the advancement of comprehensive SRHR. Finally, looking ahead, what a gender- and rights-based UHC framework can look like is considered, proposing an "intersectional feminist approach to universal health coverage" and the benefits such a perspective could contribute to advancing SRHR and UHC.

Brief Definitions/Concepts

Universal Health Coverage

Universal health coverage means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care across the life course (WHO, 2023).

Primary Health Care

A whole-of-society approach to health aims to maximize the level and distribution of health and well-being through three components: (a) primary care and essential public health functions as the core of integrated health services, (b) multisectoral policy and action, and (c) empowered people and communities (World Health Organization & United Nations Children's Fund, 2020).

Sexual and Reproductive Health and Rights

Defined by the Guttmacher–Lancet commission on sexual and reproductive health and rights (SRHR; Starrs et al., 2018), sexual and reproductive rights are based on the human rights of all individuals to have their bodily integrity, privacy, and personal autonomy respected; freely define their own sexuality, including sexual orientation and gender identity and expression; decide whether and when to be sexually active; choose their sexual partners; have safe and pleasurable sexual experiences; decide whether, when, and whom to marry; decide whether, when, and by what means to have a child or children and how many children to have; and have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence.

Sexual and reproductive health refers to health services and interventions necessary to uphold sexual and reproductive rights. These include nine interventions that comprise a comprehensive approach to SRHR and include comprehensive sexuality education; counseling and services for a range of modern contraceptives, with a defined minimum number and types of methods; antenatal, childbirth, and postnatal care, including emergency obstetric and newborn care; safe abortion services and treatment of complications of unsafe abortion; prevention and treatment of HIV and other sexually transmitted infections; prevention, detection, immediate services, and referrals for cases of sexual- and gender-based violence; prevention, detection, and management of reproductive cancers, especially cervical cancer; information, counseling, and services for subfertility and infertility; and information, counseling, and services for sexual health and well-being (Starrs et al., 2018).

Intersectional Feminism

Feminism is a social, political, and cultural movement that promotes gender equality and women's rights. Feminism aims to challenge and abolish patriarchal structures and systems that uphold gender inequality. Gender inequality is complex and multidimensional and not uniformly experienced by all individuals.

Intersectionality was introduced by Black feminist scholars in the United States as they explored the experiences of Black women. The term *intersectionality* was coined by Kimberlé Crenshaw (1991) to describe how different reasons for discrimination overlap and reinforce each other. Further, it investigates how intersecting power relations influence social relations across diverse societies as well as individual experiences in everyday life (Collins & Bilge, 2020). Intersectional feminism marries the two concepts and thus centers the voices of those experiencing overlapping, concurrent forms of oppression to understand the depths of the inequalities and the relationships among them in any given context (UN Women, 2020). Intersectional feminism is a framework for understanding how various social identities, such as race, gender, class, sexuality, ability, and others, intersect and interact with each other to create unique experiences of oppression or privilege.

This article refers to an **intersectional feminist approach** to acknowledge and account for the interconnected systems of oppression that extend beyond the axis of gender. Using an intersectional feminist framework, as will be demonstrated in this article, helps to unpack how health systems themselves perpetuate gender and intersectional inequalities. It sheds light on both underlying and direct causes of unequal treatment and access to care within the health system and is used in this article to highlight the inequalities and inequities as they relate to SRHR. The intersectional feminist approach offers a holistic framework to help structure the arguments laid out in this article.

Marginalized Groups

Different groups of people within a given culture, context, and history are at risk of being subjected to multiple discrimination due to the interplay of different personal characteristics or grounds, such as sex, gender, age, ethnicity, religion or belief, health status, ability, sexual orientation, gender identity, education or income, or living in various geographic localities. Belonging to, or being perceived to belong to, such groups heightens the risk of inequalities in terms of access to rights and use of services and goods in a variety of domains, including health, social protection systems, and justice (European Institute for Gender Equality, 2016).

Sexual and Reproductive Health and Rights in Universal Health Coverage—Progress and Challenges

The 58th World Health Assembly in 2005 is regarded as a starting point for aspiration toward universal health coverage (UHC; or simply universal coverage as it was described at the time), as member states recognized the importance of reforming their health financing systems to achieve universal coverage and addressing catastrophic levels of out-of-pocket health spending (World Health Assembly, 2005). This aspiration was further emphasized in the 2010 World Health Report, which took stock of current access to essential health services and outlined steps that countries needed to take to remove barriers to access to health care and improve financial protection (WHO, 2010b). Progress toward UHC can be measured through the UHC service coverage index (WHO, n.d.). The index is measured from 0 to 100 and has improved over the past 20 years, from an average score of 45 in 2000, rising to 67 in 2019 (WHO, 2022c). However, the pace of progress is not sufficient to reach the goal of one billion additional people benefiting from UHC by 2030. Figure 1 shows the large differences in UHC service coverage between countries. The African region has the lowest service coverage, with an average index score of 46, while the European region on average has 79, illustrating the uneven progress in access to services between different parts of the world. A recent analysis of country commitment to UHC, based on a review of 45 countries, concluded that while countries have committed to UHC, many lack a clear strategy for how to achieve it. Furthermore, the review noted that countries are not sufficiently addressing gender equality in their UHC strategies, especially with regard to women's representation in health and political leadership (UHC2030, 2021).

Sexual and reproductive health and rights (SRHR) has an undeniable place in the progress toward UHC. UHC cannot be achieved unless SRHR is addressed as SRHR covers some of the largest and basic health needs and rights of the populations across the life course. In 2019, the Political Declaration on UHC stipulated that sexual and reproductive health services and reproductive rights, in line with the International Conference on Population and Development (ICPD) Programme of Action, were to be achieved by 2030 as a key aspect of UHC. This was reemphasized in the UHC declaration in 2023. Furthermore, in 2020, during the COVID-19 pandemic, the World Health Organization clarified that comprehensive SRHR was part of essential services to be maintained during crises (WHO, 2020).

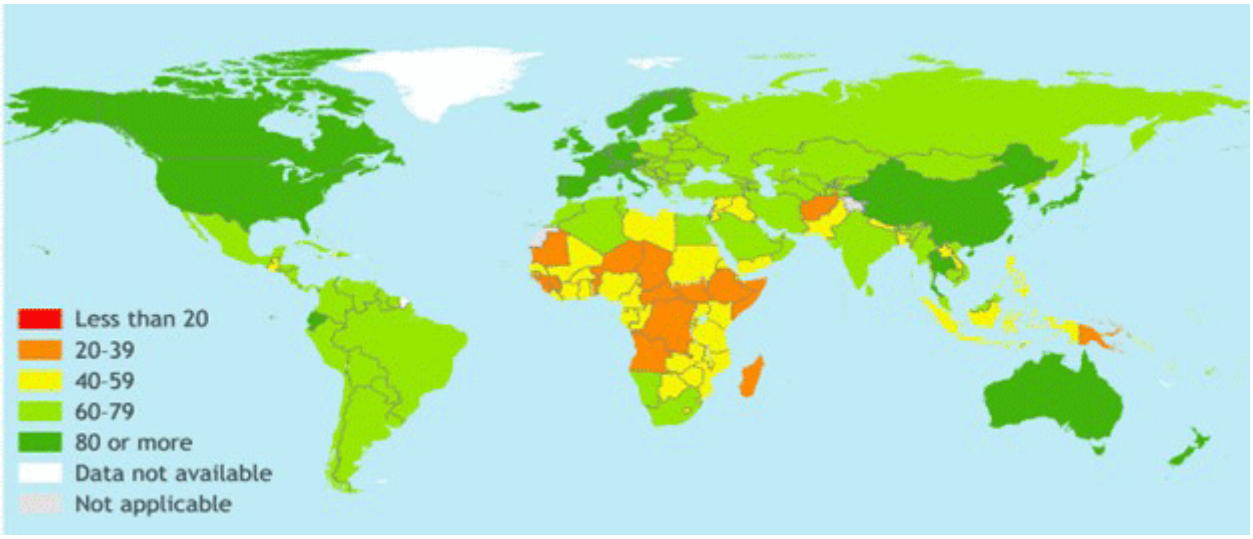

Figure 1. UHC service coverage index in 2019.

Source: World Health Organization (2022c).

Since the World Health Assembly in 2005, the world has witnessed significant progress in some key SRHR outcome indicators and at the same time mixed results in others. The number of HIV/AIDS-related deaths decreased from 1.83 million to 0.86 million from 2005 to 2019. Global maternal mortality in 2020 was estimated to be 223 maternal deaths per 100,000 live births, down from 339 in 2000. However, the decline in maternal mortality has stagnated since 2016 (World Health Organization, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division, 2023). Overall, SRHR progress has been unevenly distributed both between and within countries. For example, sub-Saharan Africa accounted for about 70% of global maternal deaths in 2020 (Figure 2; Starrs et al., 2023). People living in poverty, dealing with vulnerable situations, or facing systemic discrimination due to, for example, ethnicity, religious belief, or key populations bear a disproportionate burden of maternal mortality and morbidity and adverse SRHR outcomes. For example, maternal mortality is more than twice as high among Black women in the United States compared to their White counterparts (Hoyert, 2023).

Figure 2. Trends in maternal mortality with regional differences (2005–2020).

Source: World Health Organization (2023).

Trends in maternal mortality (Figures 2 and 3) appear closely aligned with and track trends in UHC (Figure 1). Countries and regions with higher coverage (Figure 1; light and dark green) are generally the same regions and countries that have lower maternal mortality (Figure 3). Yet, stagnating maternal mortality since 2016, despite increasing UHC service coverage, points to challenges in the design of UHC that do not sufficiently address and cater to the SRHR needs required to further reduce maternal mortality and morbidity.

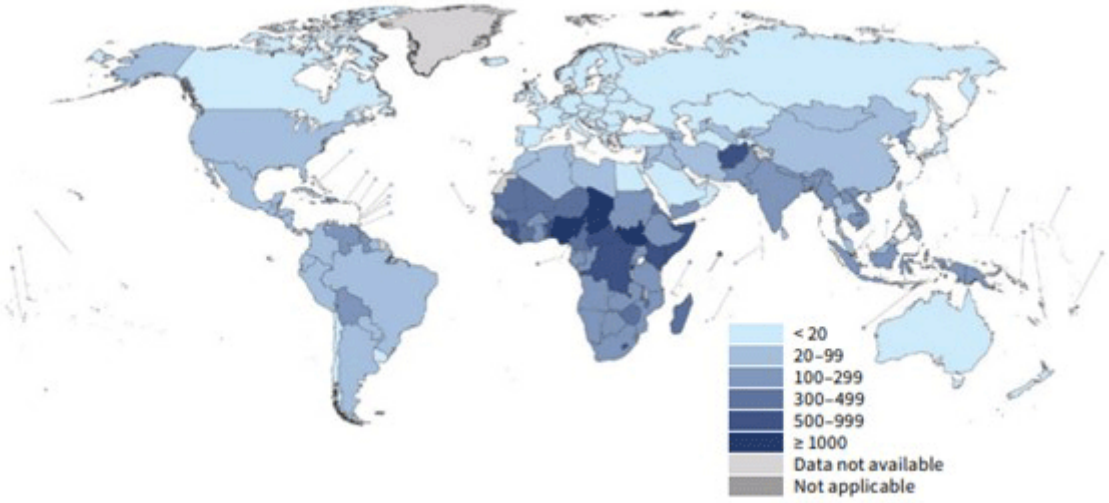

Figure 3. Maternal mortality ratio estimates by country 2020.

Source: World Health Organization, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division (2023).

Addressing Shortcomings of Universal Health Coverage in Achieving Sexual and Reproductive Health and Rights for All

While continued advancement of universal health coverage (UHC) is both desirable and critical for health, including sexual and reproductive health (SRH) services, UHC will not be sufficient for achieving comprehensive sexual and reproductive health and rights (SRHR) for all. As argued by Fried et al., UHC alone will not result in universal access to sexual and reproductive health and certainly not to sexual and reproductive rights (Fried et al., 2013). UHC, however, has the potential to deliver far better on SRHR than it currently does.

A shortcoming of the UHC framework is the limited emphasis on access to services. It is generally agreed that access to health services is dependent on the services being available, affordable, acceptable, accessible, and of good quality (Committee on Economic, Social and Cultural Rights, 2020). While UHC aims to ensure that all people have access to essential quality health services without suffering from financial hardship, the focus thus far has primarily been on the financial

aspects of health services provision, and efforts have a tendency to overlook other features of access, particularly acceptability, accessibility, and good quality, concerning SRHR as well as other services (Gruending et al., 2020). Barriers that people experience in seeking SRHR services are related to not only services not being provided or available or those that are too expensive to afford. Barriers to SRHR also include aspects that compromise quality, accessibility, and acceptability such as stigma and discrimination, cultural barriers, lack of trust, personal beliefs, long waiting times, restrictive legal and policy frameworks, mistreatment, harassment, and abuse of power (Ganle et al., 2020; Gómez-Suárez et al., 2019; Gruskin et al., 2021; Onukwugha et al., 2019; Saadat et al., 2023). Many people also experience multiple intersecting barriers in combination. The current approach to UHC, therefore, has challenges to deliver equitable health services for all.

UHC, in the way it is currently pursued, can be perceived as paternalistic. The 2023 declaration of the high-level meeting on UHC describes groups such as women, children, youth, persons with disabilities, people living with HIV/AIDS, older persons, people of African descent, Indigenous Peoples, and other groups as "vulnerable" (United Nations, 2023a). There are most certainly people currently belonging to marginalized groups or living in vulnerable situations, and UHC is not sufficiently addressing their needs, particularly those related to SRHR. However, by describing all these groups as "vulnerable," the focus shifts from UHC delivering equitable health services for all to justifying why systems are unable to adequately cater to these "vulnerable" groups, putting the burden on the people rather than on the system. Also, if vulnerable groups would indeed consist of the abovementioned groups, they would make up the majority of the world's population. Adding to this, there is very little engagement with the communities defined as "vulnerable" in the resolution; however, more important, there is hardly any engagement with the communities that actually belong to vulnerable groups in the UHC decision-making processes (Hikuam et al., 2020).

Moving toward UHC is described by the World Health Organization (WHO, 2010a) as making progress in relation to three dimensions: Who is covered by health services? Which health services are covered? What proportion of the cost for these services is covered? To achieve SRHR in UHC, a reorientation of health systems to be centered on health equity and the right to health rather than the mere provision of affordable health services is urgently needed. Similarly, there is a need to address social and gender norms influencing the design and operationalization of health benefit packages and more resources for health mobilized in a way that offers financial protection for individual households. One of the main reasons the UHC approach is insufficient is that the UHC agenda today is embedded in and shaped by patriarchal and colonial power structures and systemic barriers that perpetuate health inequities and gender inequalities. These gendered structures and barriers make it impossible to advance UHC in a way that makes it truly universal and based on the needs of the entire population. In the following sections, a number of shortcomings of the current UHC framing are highlighted, along with a discussion of how an intersectional feminist approach to UHC could help overcome these limitations. This argument is structured around the WHO framework for UHC, defining the objectives of UHC to (a) improve equity in access, (b) reduce the financial risk of ill health, and (c) provide person-centered and good-quality services to improve health (Table 1). Examples of these shortcomings are presented

in Table 1 and in the four case studies that illustrate specific challenges in relation to rights and gender inequality and how they relate to the three objectives of UHC. Each case study offers perspectives to underline the importance of new thinking around how UHC can be advanced to ensure that access to health is equitable and truly universal.

Table 1. Examples of SRHR Shortcomings of the Current UHC Framing

Dimension of UHC (WHO)	Key objectives of UHC	Examples of SRHR shortcomings of the current UHC framing
Population coverage	Equity in access	• Inadequate and excluding rights language in existing legal and policy frameworks • Lack of adequate information about rights hindering access, accountability, and enforcement of rights • Discrimination and harassment of people currently belonging to marginalized groups (LGBTQIA+) or seeking particular services such as abortion • Discriminatory social, cultural, and gender norms • Stigma related to SRHR • Inadequate and biased indicators to measure success
Financial protection	Reducing the financial risk	• Limited social protections mechanisms for people belonging to marginalized groups and in informal sectors • Limited political willingness to fund comprehensive SRH services across the life course using national funding • Key SRHR interventions e.g., contraception, abortion care, and gender-affirming treatment are not included in health benefit packages • Drivers of out-of-pocket expenditure not sufficiently addressed in the UHC approach
Service coverage	Services of sufficient quality to improve health	• Lack of respectful and person-centered SRH care • Inadequate privacy and confidentiality in service provision • Inadequate, inaccessible, or false information about services hindering informed decisions • Unhealthy and unsafe working environment and conditions for health care providers, particularly women health workers • Inadequate training of health care providers in rights-based and patient-centered care, particularly in relation to the provision of SRH services across the life course • Conscientious objection to the provision of abortion care

Dimension of UHC (WHO)	Key objectives of UHC	Examples of SRHR shortcomings of the current UHC framing
		• Deprioritization and shortage of SRH medicines and supplies, impacts of conflicts, disasters, climate change, fundamentalism (e.g., global gag rule), decreasing public health expenditure, reliance on donor funding • Inadequate and biased indicators to measure success

Sources: Angolile et al. (2023); Autorino et al. (2020); Boydell et al. (2023); Costa (2023); RamPrakash and Lingam (2021); Fanganiello et al. (2017); Devakumar and Yates (2016); Zampas et al. (2020); Nagle and Samari (2021); Kia et al. (2021); Pandya and Redcay (2021); Scheim et al. (2022); United Nations (2023a); WHO (2022a); Hepburn et al. (2021); Ravindran and Govender (2020); Forouzan and Guarnieri (2023); Ganle et al. (2020); Gruskin et al. (2021); Gómez-Suárez et al. (2019); Liu et al. (2018); Kaiser et al. (2023a); Kaiser et al. (2023b).

Case 1: Population Coverage—The Case of Transgender and SRHR in UHC

Adequate and effective financial protection for health has remained out of reach for many women and LGBTQIA+ individuals owing to a lack of an equity focus in UHC plans. The case illustrated here underlines how UHC schemes that do not address systematic discrimination or stigma faced by trans and gender-diverse individuals translate into significant barriers such as lack of available, accessible, acceptable, and quality services; exclusion of gender-affirmative treatments in essential packages; lack of accountability to create a culturally trained health care workforce; and weak financial protection. UHC has been a weak force to make a dent in the larger political forces that have rekindled fundamentalism, denied legal recognition, and pushed back on LGBTQIA+ rights.

Transgender[2] individuals suffer significant health disparities and are at higher risk of a range of diseases, including mental illness, HIV/AIDS, substance use, and chronic diseases (Costa, 2023). Despite available evidence that the transgender population suffers multiple and intersecting health risks, they have largely been excluded from UHC policies and programs.

Close to 67 countries have national laws criminalizing homosexual relations, and at least nine countries criminalize gender queer people (Human Rights Watch, n.d.), thereby denying their rights and restricting their access to health care. However, merely providing legal recognition does not automatically improve health care access for transgender individuals, as in the case of South Africa, where sexual and gender minorities have been explicitly guaranteed nondiscrimination and a right to access to health care (Müller, 2017). Several factors, including personal and social factors, play a role. A recent systematic review (Costa, 2023) identified service delivery barriers such as the failure to acknowledge

the existence of transgender people as patients within the health system (denial and abuse) and policy barriers (such as lack of legal recognition and guidelines) as major hurdles in the realization of their right to health.

Transgender individuals are disproportionately represented among the poor, engage in irregular work arrangements, and lack social security benefits (Kia et al., 2021; Pandya & Redcay, 2021; Scheim et al., 2022). Therefore, advancing UHC through employment-based insurance systems is likely to exclude LGBTQIA+ individuals because of their disproportionate participation in the formal sector or the increased risk of losing their jobs due to discrimination (Mayer et al., 2008), thus contributing to intersectional marginalization. Even in government-sponsored health insurance schemes, eligibility criteria based on membership to heteronormative "families" and documentary proof have excluded transgender individuals (RamPrakash & Lingam, 2021). Most countries around the world have neither facilitated transgender persons to access health insurance nor included gender-affirmative services in their national essential health services packages (Mayer et al., 2008). During the COVID-19 pandemic, disruptions to affirmation services resulted in negative health outcomes, reiterating the need for certain gender-affirmative treatments to be recognized as an essential set of services in health care (Koehler et al., 2021). In 2023, India and Thailand became the first Asian countries to include gender-affirmative care in their publicly funded health insurance policies. There is emerging evidence that services for LGBTQIA+ individuals, even when made available, may be of poor quality or even abusive, primarily due to inadequate training of providers (Fanganiello et al., 2017; RamPrakash, 2023).

Case 2: Service Coverage—The Case of a Missing Continuum of Respectful Care for Women[3] Through the Life Course

A woman-centered quality-of-care approach that creates an enabling environment for mutual trust, respect, and informed and shared decision-making throughout the life course of women from adolescence to postmenopausal stages is missing in the current UHC framework and manifests particularly in the provision of SRH services. This case examines mistreatment and cesarean sections surrounding childbirth and illustrates how, without an explicit attempt to address gender norms and power inequalities, services under UHC can have unintended negative health and SRHR consequences, violating rights and compromising gender equality.

Mistreatment manifests as disrespectful, abusive, or neglectful treatment during childbirth in facilities, including coercive or unconsented medical procedures (including sterilization and cesarean section), lack of confidentiality, refusal to give pain medication,

gross violations of privacy, refusal of admission to health facilities, harassments and use of abusive language, and neglecting women during childbirth. Related to this is the practice of detaining women when either they or their families fail to pay the hospital costs, even in contexts where specific groups of people are exempt from fees (Devakumar & Yates, 2016). The various forms of mistreatment and abuse are a violation of the rights of women and their right to quality maternity care and have consequences for eroding trust in health care providers and the wider institutions underpinning the health system (Govender et al., 2022). Experiences of mistreatment and abuse are disproportionately experienced by women who are marginalized (e.g., Indigenous populations, ethnic minorities, women with disabilities, women living with HIV) (Zampas et al., 2020). As noted by Govender et al. (2022), "With few exceptions, childbirth represents one of the most critical encounters between women and their communities, and the health system. During childbirth, trust and quality of care are paramount."

Cesarean section (CS) is a critical obstetric surgical intervention in high-risk pregnancies, and when medically indicated, it is considered a life-saving procedure for women and the newborn. CS service delivery faces two major challenges: underprovision and unacceptable unmet need, especially in low-income settings, and overprovision, both sustained by information and power asymmetry in health systems. CS procedures that are medically unnecessary are on the rise globally, accounting for more than one in five (21%) of all childbirths (Betran et al., 2021). While CS procedures might be necessary and can be lifesaving in specific circumstances, unnecessary CS is risky for women and babies and, in contexts of the absence of publicly funded health care or health insurance, places a financial burden on the household and has further economic implications on the health system (Liu et al., 2018). A complex range of factors drives overprovision of CS (Angolile et al., 2023). Structural sexism, linked to social views and norms of women and their bodies, is recognized as a driver of overmedicalization of birth (Nagle & Samari, 2021). Several nonmedical factors have been identified as driving the rise in unnecessary CS, and these include preferences by physicians in terms of convenience in timing, financial incentives for private physicians and private hospitals, physician's fear of litigation after a vaginal birth, and requests by women driven by fear, anxiety, and apprehension over pain during labor and delivery (Angolile et al., 2023). While overprovision of CS is on the rise, there are huge gaps in access to CS in LMICs where medically justified; some of the factors driving CS underprovision include lack of health infrastructure (equipment and/or supplies) and human resources and/or skills (doctors, midwives, anesthetists).

Case 3: Service Coverage—The Case of Unhealthy and Unsafe Working Environment and Conditions for Health Care Providers, Particularly Women Health Workers

A healthy, safe, qualified, and adequately resourced workforce is a cornerstone of a resilient health system and a prerequisite for UHC and the provision of good-quality care. The following case illustrates how this is a neglected and gender-blind dimension of the current UHC framework that can result in negative consequences for access and financial protection.

The compromised safety and well-being of health service providers undermines the provision of care, particularly for women and people currently belonging to marginalized groups. Similarly, substandard education and limited learning opportunities, as well as the lack of a clear scope of practice and division of roles within the health system, have direct negative implications for the quality of care. For example, research across Africa and South Asia has shown that inadequate education and training jeopardize not only the competence but also the professional identity and confidence of midwives as primary SRH care providers (Filby et al., 2016). The 2023 Political Declaration on UHC (United Nations, 2023a) recognizes the "training, developing, recruiting and retaining a skilled health workforce, as fundamental to strong and resilient health systems, while stressing the need to improve working conditions and management of the health workforce to ensure the safety of health workers, inter alia from all forms of violence, including sexual and gender-based violence, and harassment in the workplace and the lack of adequate infection controls and protections, as well as stress, burnout and other impacts on mental health" (para. 39). The declaration, however, does not recognize that the issue of workforce is gendered, although an estimated 67% of health workers are women (Gilmore et al., 2022; WHO, 2019).

According to the World Health Organization, there is a global shortage of 7.2 million health workers, which is projected to increase to 12.9 million by 2035. Among these, there is an estimated shortage of 900,000 midwives globally, and at the current pace of educating new midwives, this shortage will increase over the coming years due to population growth (UNFPA, International Confederation of Midwives and World Health Organization, 2021). The health worker shortage affects the availability and quality of SRHR services, especially in low- and middle-income countries. It also affects the working conditions and circumstances under which the existing workforce operates.

In a scoping review (Boydell et al., 2023) on hostilities faced by people on the frontlines of SRHR, the authors concluded that hostilities against frontline SRHR workers occur across the globe. However, due to severe underreporting, the phenomenon has remained largely invisible in the evidence and thus receives far too little attention. Hostilities are often categorized as exceptional events or an "inevitable" part of daily work that is to be

tolerated. The SRHR workers are also overwhelmingly female, clearly exemplifying the systematic gendered discrimination against women health workers and health workers working on "women's issues."

Case 4: Intersecting Barriers in All Three UHC Dimensions—The Case of Access and Right to Abortion

This case uses the example of comprehensive abortion care and offers perspectives that cut across all three dimensions of UHC, including population coverage, financial protection, and quality of health services, the impact of which is seen also in high-income countries.

There is strong evidence that access to comprehensive abortion care (CAC)[4] is necessary to achieve health and well-being for all (WHO, 2022a), and it is fundamental to uphold sexual and reproductive rights and gender equality. Abortion, on various grounds, is legal in most countries globally and is only prohibited altogether in 22 countries; it does, however, vary by state in the United States and in Mexico (Center for Reproductive Rights, 2022). Despite this, comprehensive abortion care is excluded from UHC packages (Hepburn et al., 2021; Ravindran & Govender, 2020). Abortion often contributes to increased out-of-pocket expenditure (OOP) on behalf of women and their families, thus having an impact on access to services and implications for financial protection. A review of OOP expenditures for health in the United States shows that women overall have a higher financial burden than men and that a significant share of this burden is due to maternal health services, including abortion services (Deloitte, 2023). In 2022, the US Supreme Court eliminated the constitutional right to abortion established by *Roe v Wade*, allowing states to decide if and when abortion is legal. Since the decision, 14 states have enforced total bans, and 7 more have restricted access to abortion, resulting in access to CAC being restricted for millions of people across the country. This means that anyone who is denied abortion access in their own state is forced to seek care out of state, self-manage, or carry an unintended pregnancy to term, all with cost and health implications disproportionately affecting those marginalized by economic insecurity and structural racism in the United States (Forouzan & Guarnieri, 2023).

In addition to policy and legislative barriers, other sociocultural and health systems barriers may challenge access to CAC, including, for example, systemic discrimination based on ethnicity, availability of information, availability and cost of self-management of medical abortion, stigma, availability of skilled and competent health care providers, and willingness of health workers to provide care and, in some instances, refusal to provide abortion care on the basis of personal conscience or religious belief (i.e., conscientious objection or conscientious refusal; WHO, 2022a).

In countries such as Italy, although abortion is free of charge and legal, conscientious objection is a serious barrier to accessing abortion services. Gynecologists are granted the right to refuse to perform abortions on the grounds of religious or moral beliefs. More than two thirds of gynecologists (71%) are registered as conscientious objectors, and only 60% of hospitals with an obstetrics and gynecology ward offer abortions (Autorino et al., 2020). Autorino et al.'s study of whether conscientious objection had an impact on access to abortion services found it did adversely affect access, especially for women living in lower-income regions or experiencing other forms of economic disadvantage.

An Intersectional Feminist Approach to Universal Health Coverage—A Value Proposition

This article has reviewed what universal health coverage (UHC) set out to achieve and to what extent it has integrated sexual and reproductive health and rights (SRHR) under its ambit and advanced it from a gender and rights perspective. UHC aspires to provide health coverage for all, but in its current form, it fails to do so, particularly in relation to SRHR. There is a conspicuous absence of focus on addressing unequal power structures between users and health systems and within the health systems, crucial to building trust and respect within the UHC framing. The shortcomings of UHC in relation to SRHR, as laid out in Table 1 and exemplified in the four case studies, demonstrate the absence of a health equity, gender equality, and human rights lens in the current UHC framing.

While the intention for UHC has always been progressive realization, the current design and operationalization are flawed by gender and power inequalities, lack of participation of diverse groups in decision-making, and inadequate measurement frameworks. The cases illustrate the systemic mistreatments faced by women, girls, LGBTQIA+ individuals, and others currently belonging to marginalized groups, who remain invisible in the existing UHC planning, design, and measurements for monitoring, exercises that are increasingly devoid of any rights language (Khosla & Bertram, 2023). For example, while access (often measured through its proxy-utilization) may increase, it need not always indicate progression toward realization of SRHR, as exemplified in the case of the rise of unnecessary cesarean sections (Case 2).

Case 2 (cesarean sections) and Case 4 (abortion access) highlight that access to a fundamental health service such as comprehensive abortion care is excluded from UHC benefit packages while a more complex, expensive, and higher-risk procedure such as cesarean section is oversupplied and remains unregulated and unquestioned. While access to comprehensive abortion care must be normalized and included in health benefit packages as the essential service that it is, access to cesarean sections must be regulated. An intersectional feminist approach would go beyond "one size fits all" and rethink indicators of UHC progress beyond "coverage" and "access" to measure if information and power asymmetries between women, girls, and health systems are addressed and bodily autonomy protected. A gender-based audit of utilization trends and elimination of

unnecessary procedures needs to be a regular exercise within the health system. Marginalized and excluded communities actively participating and voicing their concerns in designing, implementing, and monitoring UHC plans would become an uncompromisable indicator in an intersectional feminist approach. Case 2 also illustrates that it is important to recognize and address the structural sexism that underpins and allows for continued mistreatment of women in childbirth and shift the focus toward the provision of quality and person-centered care free from abuse and harassment. Shared decision-making should be encouraged even if it means opt-out decisions, supporting women through their life course, as well as training providers on respectful person-centered care. Case 3 (working environment) illustrates the consequences of substandard, unsafe, and sexist working environments on quality of care, a reality particularly affecting women health care providers. A feminist approach to UHC would recognize that respectful care of users has to start with respectful care of health workers. The approach further demands a gendered solution inter alia dedicated investments in women health care providers, including women health workers in decision-making processes in relation to UHC policies and packages, investing in women's leadership, and recognizing and addressing the harassments and threats that are directed toward sexual and reproductive health (SRH) care providers in particular, those directly implicating access to SRH services.

Case 1 (transgender) illustrates the complex and pervasive intersectional barriers faced by LGBTQIA+ communities. An intersectional feminist approach to UHC would acknowledge and address these barriers and explicitly aim to include relevant services in its health packages, especially through primary health care. It would also ensure that services required by this group, such as gender-affirming care, including mental health, are not excluded from benefit packages for reasons of lack of scale (the proportion of LGBTQIA+ in the population might be small) or limitations in cost-effectiveness. Perhaps an intersectional feminist approach to UHC can pave the way for challenging and aligning the socio-political-cultural determinants, such as decriminalization and legal recognition for LGBTQIA+.

The case studies illustrate inadequate investment in, and respect for, women health workers, violations of autonomy and dignity, lack of accountability, and power of politics, all of which cannot be removed by merely focusing on the "ability to pay" or financial barriers to health care alone. Based on this, the current UHC framing is insufficient to progressively realize SRHR in UHC, and therefore there is a need to rethink the framing and its design.

Consequently, an intersectional feminist approach to UHC is proposed to address many of the shortcomings highlighted in this article. An intersectional feminist approach to UHC would require an analysis of the power dynamics underpinning health outcomes at large, particularly necessary to enhance SRHR. It would pinpoint barriers to health care across the three UHC dimensions for different population groups, and finally it would offer perspectives on how to address these within each given context. While recognizing that prioritizations in defining health packages and financial protection mechanisms must be made, it is crucial that such prioritizations are transparent and that there is a plan to progressively realize UHC, including SRHR, for all over time. Similarly, the measure of success must be scrutinized to better reflect the diversity of needs and put greater emphasis on access to care, including aspects of acceptability

and quality, such as respectful and person-centered care. Applying an intersectional feminist approach to UHC would call for actions to normalize the right to SRH as an essential component of UHC, making SRHR more resilient to political shifts.

Shifting mindsets and including a proper gender and power analysis in the UHC design, operationalization, and measurement of UHC outcomes will allow for truly achieving the UHC objectives of financial protection, equity in access, and service quality. An intersectional feminist framework to UHC would not only improve SRHR outcomes but also serve to improve health outcomes at large. However, it is also recognized that UHC will not be the silver bullet for achieving comprehensive SRHR since many aspects of SRHR sit outside the health sector in powerful political and economic factors that defy the obvious. Now more than ever, UHC finds itself embedded in the context of political pushback against SRHR and LGBTQIA+ rights. A gender- and rights-based UHC framing, as proposed in this article, has the potential to challenge the larger political and economic context and facilitate necessary changes for realizing UHC and comprehensive SRHR as an essential part of that.

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Notes

1. Paragraph 62: Ensure, by 2030, universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs, and ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

2. Transgender people have a current gender identity or expression that is different from the sex assigned to them at birth.

3. In this section, trans women and birthing persons are included under the umbrella term of *women*.

4. Comprehensive abortion care includes provision of information, abortion management (including induced abortion and care related to pregnancy loss), and postabortion care (WHO, 2022a).

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