Title: Can universal health coverage eliminate unsafe abortion?

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Abstract

Progress towards universal health coverage could lead to transformational improvements in health worldwide. Although the goal of universal health coverage (UHC) unites the global health community, UHC alone cannot end the mortality and morbidity caused by unsafe abortion. Simple, safe and effective interventions exist for abortion care but high levels of unsafe abortion persist, driven by restrictive laws and policies, limited funding allocation, low service coverage, lack of knowledge, and abortion stigma. This commentary explores how universal coverage can support the elimination of unsafe abortion by including abortion in essential services packages, expanding access to care, addressing financial and social barriers and including abortion access within monitoring indicators. The commentary also discusses issues beyond UHC that must be addressed in order to eliminate unsafe abortion, including removal of restrictive abortion laws and policies as well as combatting abortion stigma.

Article

Simple, safe and effective interventions exist for abortion care, but almost half of the 73 million abortions that occur each year are unsafe, causing 8-11% of maternal deaths – almost all of which are preventable (Singh 2018, Bearak 2020)**.** Unsafe abortion disproportionately affects low- and middle-income countries (LMICs), with 97% of unsafe abortions taking place in these contexts (Singh 2018), largely due to restrictive abortion laws and policies. In high-income countries, 81% of women can have a legal abortion with no restriction on their reason for the abortion, compared to 29% in LMICs (Singh 2018). In addition to restrictive laws and policies, high levels of unsafe abortions are driven by

inadequate funding and coverage of abortion services; poor provider knowledge and attitudes; low levels of community awareness; and abortion stigma. When unable to access this essential health care, women are denied their human right to determine whether or when they have children, and may be forced to continue unwanted pregnancies or end pregnancies in dangerous and degrading ways.

Achieving universal health coverage (UHC) means that everyone can access the health services they need without financial hardship, irrespective of their ability to pay (Wagstaff 2020). It involves a shift away from direct, out-of-pocket payments for health care and a shift towards governments raising more funds for health, pooling funds effectively to spread risks and becoming more efficient in their use (WHO 2010). UHC also incorporates wider objectives of improving health service quality and equity, and it therefore involves the entire health system, not only health financing policy (Kutzin 2013). Achieving UHC (including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all) is one of the targets of Sustainable Development Goal 3 to 'Ensure healthy lives and promote well-being for all' (UN 2015). UHC is clearly an important driver of the global health agenda, and increasing global commitment to this goal has seen many countries pursue UHC-focused health reforms (Wagstaff 2020).

Within SDG 3, UHC sits alongside targets for specific health outcomes such as reducing maternal mortality and ensuring universal access to sexual and reproductive health (SRH) care. UHC and SRH goals are mutually reinforcing: UHC cannot be achieved without fulfilling the SRH needs and rights of populations but UHC can help drive progress towards SRH goals (Ravindran 2020). Progress towards UHC may therefore support the elimination of unsafe abortion: stronger health systems with quality services, a well-performing workforce, a well-functioning information system, equitable access to essential medicines, a good financing system and strong leadership and governance (WHO 2007) could jointly result in increased availability of accessible, affordable, quality health care, including abortion. However, the potential impacts of UHC depends on how it is designed and implemented.

This commentary assesses how UHC can impact access to safe abortion, and what else is needed to bring an end to unsafe abortion. Evidence about the effectiveness of financing, service provision and accountability initiatives to achieve UHC for SRH is lacking, particularly regarding access to safe abortion (Ravindran 2020). However, this commentary provides an overview of potential challenges and priority actions for the contribution of UHC to abortion access, and identifies areas requiring further exploration.

How can universal health coverage impact access to safe abortion?

Quick et al (2014) identify five key challenges for the design and implementation of UHC to improve women's health and equity: the essential services package, access to services, financial barriers, social barriers, and performance-monitoring indicators. We consider each of these in turn, assessing how these challenges apply specifically to abortion, and what further actions are needed for UHC to support the elimination of unsafe abortion.

The first of these, the essential services package, is critical for UHC to address unsafe abortion. Even where abortion is less legally restricted, it tends to be excluded from the benefits package of public and private health insurance (Quick 2014, Ravindran 2020): only 46% of women living in countries with liberal abortion laws can also access full public funding for abortion, despite maternity care being fully covered (Grossman 2014). UHC must explicitly include abortion care and post-abortion care if it is to contribute to elimination of unsafe abortion. From a public health and human rights viewpoint, abortion is essential health care, and the Covid-19 pandemic has clearly reaffirmed this. From an economic viewpoint, inclusion of abortion care in health benefits packages could markedly reduce health system expenditure on the emergency post-abortion care (PAC) required to treat complications from unsafe abortion: recent estimates indicate that the direct cost of providing a safe abortion service in LMICs is US$12, while the average direct cost of providing a PAC service for shock, sepsis, uterine perforation or haemorrhage is US$75 (Lince-Deroche 2020). There have been promising shifts towards the inclusion of abortion and post-abortion care in essential service and health benefits packages in a few countries in recent years, achieved with support from evidence-based and diligent advocacy by civil society organisations (Monga 2020). For example, Nepal's Basic Health Service Package includes safe abortion care at public health facilities, and Nepal's government has committed to making abortion free of charge at the point of use, a process that has begun to enable access through public services and through private sector contracting. Although a causal link cannot be proved, Nepal has seen increases in the safety of abortion and use of government facilities over the years that these reforms have taken place (Monga 2020).

The second critical challenge is to ensure health services are accessible. Quick et al argued gender-equitable UHC could be achieved through the promotion of integrated, localised services, support for pharmacy provision and task-sharing (Quick 2014). These factors are also important for increasing the accessibility of abortion care: pharmacies have become critical sources of abortion medications, and a growing body of evidence highlights that mid-level and low-level providers can safely provide abortion care, though task-sharing is often inhibited by legal and policy restrictions. In addition, we also argue that expanding the

coverage of safe abortion care through public sector strengthening and partnerships with private and informal sector networks will be crucial to improve access. The role of the private sector in health coverage remains contested, and more evidence is needed about the contribution of the private sector to UHC for SRH more broadly (Ravindran 2020). However, the involvement of the private sector in health is significant and cannot be ignored in efforts to move towards UHC (Clarke 2019): for example, within SRH, the private sector has been estimated to provide 37-39% of contraceptive services in LMICs (Campbell 2015).

As a priority, public sector capacity to provide abortion care must be strengthened, in terms of clinical competency and infrastructure (supplies, equipment), as well as providers' understanding and acceptance of the need to provide safe abortion care. This is particularly true in early stages of transition from more to less restrictive abortion laws, when partnerships with non-governmental organisations have often played an important role in supporting development of clinical guidelines, clinical training, supportive supervision and provider behaviour change in the public sector (Monga 2020). The historical legacy of legal restrictions on abortion and the exclusion of abortion from the public health system in many countries, however, means that the private sector (for-profit, non-profit, formal and informal), are often important sources of abortion care. Governments can build on this existing capacity for safe abortion care: in some countries, such as South Africa and Colombia, the demand for abortion services continues to be partially met by contracting non-governmental organisations, while others, such as Mexico, have relied more heavily on the public sector (Chavkin 2018).

Improving the safety of informal sources of care is also an important strategy to eliminate unsafe abortion, as their use often continues even when legal restrictions on abortion are removed (Chemlal 2019). For example, informal providers of safe abortion care such as safe abortion hotlines and feminist accompaniment networks have expanded access within legally restrictive environments, and informal provision of medication abortion by private pharmacies has transformed abortion access in many countries. In India, for example, 73% of all abortions in 2015 were medication abortions outside health facilities (Singh 2018). While informal provision of medication abortion has improved abortion safety worldwide by replacing unsafe methods of abortion (Singh 2018), supportive co-ordination with the non-public sector by national governments is required if it is to support UHC objectives for quality and equity (Clarke 2019). For example, improved oversight of manufacturers, distributors and pharmacy vendors can help to ensure that high-quality products with high-quality information are available through pharmacies, rather than counterfeit or ineffective products. Public and non-public actors play critical roles in increasing access to safe abortion care,

which must be harnessed within the design of UHC to meet all women's needs for high quality, confidential and accessible abortion care.

The third challenge - financial barriers - is also important for abortion care. Abortion stigma compounds issues of financial access: the need for secrecy can prevent women and girls from accessing resources to pay for services or using their health insurance, and secrecy can facilitate informal requests for payment or extortion by health providers. Out-of-pocket payments are the dominant source of funding for reproductive health care in many countries, which can result in catastrophic health expenditure, particularly for abortion-related care (Ravindran 2020). Inclusion of abortion within the health benefits package and increasing public funding for SRH is critical to remove financial barriers and minimise out-of-pocket payments. Progress towards universal access to safe abortion also requires addressing funding gaps for SRH services which result from insufficient government spending and fluctuations in external donor funding, as well as exclusion of critical services like safe abortion from the Global Financing Facility and country investment cases (WHO 2020) and from many global health donor funds. Where out-of-pocket payments persist, increasing transparency and improving communication of pricing will be critical, as perceptions that unsafe or informal options are cheaper can drive women away from safer care despite the higher costs of unsafe abortion (Chemlal 2019).

The fourth challenge, of social barriers, is possibly the most substantive limiting access to abortion care, and we return to discuss this in the final section. Even in settings where abortion is available, poor knowledge of the law and concerns about confidentiality prevent women from seeking safe care (Chemlal 2019). Interventions are needed that can raise public awareness about rights and options for accessing abortion, as are ongoing efforts to de-stigmatise abortion through media campaigns, community engagement, and comprehensive sexuality education. Social norms surrounding abortion also affect providers, who may refuse to offer abortion care, thus reducing accessibility of safe services, or who may stigmatise their clients - fear of mistreatment at formal clinics is another reason for continuing use of informal abortion care (Chemlal 2019). Interventions such as values clarification and attitude transformation workshops, and providers share workshops, have been found to influence provider attitudes to abortion and/or reduce provider stigma, and wider adoption of such tools at earlier stages of medical training may improve accessibility of care.

Finally, the fifth challenge is performance monitoring indicators for UHC. In addition to the other essential health services that were identified by Quick et al, availability of abortion must be included in monitoring indicators. Abortion is commonly excluded from such

indicators, for example contraceptive access is tracked as one of sixteen signal functions of UHC provision at the country-level by the WHO, but abortion access is not included in this list (Monga 2020). In addition to tracking the availability of abortion care, efforts to monitor resource flows for SRH, key equity indicators and quality of SRH services (WHO 2020) should specifically include abortion. Evidence about abortion is often lacking at the national level due to its exclusion from vital statistics, health records and health surveys, but for unsafe abortion to be eliminated, we must end the exclusion of abortion from data sources and indicators.

What more is needed?

Progress towards UHC, if it were designed and implemented with abortion in mind, could radically improve access to safe abortion. For UHC to fulfil this promise, however, two further intertwined areas of priority action are needed: the laws and policies that restrict access to abortion must be removed and abortion stigma and its underlying causes must be addressed.

UHC cannot improve access for the 42% of women worldwide living in countries where abortion is highly legally restricted (Singh 2018). Countries with more legal restrictions on abortion have more unsafe abortions, with the proportion of abortions that are least safe ranging from 1% in the least-restrictive countries to 31% in the most-restrictive countries (Singh 2018). UHC cannot eliminate unsafe abortion if unnecessary and outdated policies restrict abortion access to specialist providers and high-level facilities, or if multiple doctors' signatures are required despite severe health worker shortages. Abortion laws and policies must be reformed, with abortion de-criminalised and unnecessary clinical restrictions removed. This is a long-term goal, and one that requires fierce advocacy from civil society using evidence on the impacts of unsafe abortion and the safety and feasibility of providing abortion care at the community level (Monga 2020). In the absence of laws and policies that support safe abortion, ensuring access to high quality post-abortion care is critical. Post-abortion care reduces mortality and morbidity from unsafe abortion, and its availability has been shown to support the scaling up of safe abortion care following legal reform: in Nepal, Ghana and Ethiopia, providers were familiar with clinical abortion techniques and were ready to deliver scaled services due to their experience offering post-abortion care (Chavkin 2018). But access to post-abortion care still suffers critical gaps in many countries so building health system capacity for post-abortion care is essential to reducing harm from unsafe abortion and preparing the public sector to scale up safe abortion access in future.

Abortion stigma exacerbates each of the challenges that prevents UHC from eliminating unsafe abortion. Rooted in socio-cultural norms surrounding gender, femininity and

motherhood (Kumar 2008), abortion stigma is produced by the political forces that legally restrict abortion, resist inclusion of reproductive rights within UHC and the SDGs, criminalise women (and those who help them) if abortions are obtained outside of prescriptive circumstances; exclude or side-line abortion from health benefits packages or national training curricula; and create excessively restrictive clinical policies that limit where abortion can be provided and who can provide it. These factors combine to limit the availability of safe services, exacerbate issues such as health worker shortages, and legitimise providers' refusal to offer abortion care. Stigma also exacerbates the issues of geographic and financial access, for example the need for secrecy can prevent women from visiting their nearest provider or accessing funds to pay for care.

Progress towards UHC is an inherently political process, and while abortion stigma pervades political decisions about access to health care, we cannot expect that progress towards UHC will eliminate unsafe abortion. But change is possible. Though there is limited evidence of interventions that can reduce abortion stigma, recent progress in Nepal and Pakistan has highlighted how stigma within UHC decision-making can be overcome through partnerships between state and non-state actors, recruitment of powerful allies and provision of local evidence about the urgent impacts of unsafe abortion and the potential of safe and effective technologies to address them (Monga 2020). At the service provider level, values clarification and attitude transformation workshops can address stigmatising attitudes limiting access. At the community level, the effects of stigma can be tackled by working with community health actors to raise awareness of needs, services and options. And approaches that have successfully supported women to self-administer medical abortion using hotlines and community accompaniment models to deliver advice and support may also contribute to the normalisation and de-stigmatisation of abortion care.

Conclusions

UHC is critical for the expansion of access to affordable, quality health services for all. While the push to ensure UHC is crucial to improving health outcomes, these efforts will not eliminate unsafe abortion unless they specifically include abortion in the design of benefits packages, increase availability of safe abortion care within the public sector and through partnership with non-public sectors, ensure adequate financing, overcome social barriers and include abortion in key progress indicators. While our community must work tirelessly to address legal and policy barriers to abortion, we must also work to ensure maximum access to quality post-abortion care in those settings where legal abortion is not yet a reality. Efforts to reduce abortion stigma through the normalisation of abortion in policy and public discourse – through rights-based advocacy, health worker education, community and religious leader engagement, mass media – will be crucial for UHC efforts to succeed in

improving the safety of abortion. Further evidence is needed on the contextual factors and processes that can encourage universal access to abortion, including the role of the non-public sector, interventions that can combat abortion stigma among different groups, and effective mechanisms for increasing public awareness about abortion rights and entitlements. While the Covid-19 pandemic has posed additional challenges (and some opportunities such as expanded telemedicine approaches) for improving access to safe abortion care, it has also re-affirmed that abortion care must be designated an essential health service for human rights to be upheld. Urgent action is needed for unsafe abortion to be eliminated, and UHC can further this goal through the inclusion of abortion within its design and implementation.

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