

Universal Health Coverage
and access to
reproductive health and
family planning supplies

**A Systematic Review
of the Evidence**

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Abstract

The recently adopted Sustainable Development Goals (SDGs) recognize that ensuring universal access to reproductive health (RH) services, and integrating RH into universal health coverage (UHC) programs and strategies are critical to reducing global maternal mortality. As countries move forward in pursuit of expanding coverage of RH services, they must ensure that the commodities required to deliver these services are available and affordable. Many countries have already begun these efforts and it is important to understand how FP/RH commodities have been covered in existing UHC strategies and how supply chains have been affected as UHC schemes are rolled out so that other countries just embarking on these efforts can learn from past experiences. To this end, we undertook a systematic literature review looking for evidence of the effects of UHC schemes on access to RH/FP commodities and on supply systems. Our purpose was to identify lessons learned and recommendations regarding how supply chain systems have been adapted to increase availability, accessibility and affordability of reproductive health medicines and supplies. We anticipated that the review could provide an evidence base that could be used to advocate for best practices to governments, civil society and other stakeholders. The overarching question guiding our review was how do different strategies for achieving UHC affect access to medicines and commodities for family planning, reproductive health, and maternal health? Our search of both published and grey literature yielded 164 publications that described a UHC strategy or program and reproductive health supplies. We found no articles that directly answered the research questions, but found a number of articles that indicated that lack of availability of commodities was a major challenge in UHC efforts. The paucity of publications found that measure or even describe the effects of implementation of UHC strategies on supply chain systems for RH demonstrates the urgent need to analyze and document evidence on this topic from countries that have already moved forward in the process. The realization of the aspirational goal of universal health coverage implies strategic systems thinking and investment. In order to achieve SDG3, and the specific targets related to universal access to reproductive health services and supplies, and universal health coverage, countries will need to focus more on supply systems strengthening.

Introduction

The recently adopted Sustainable Development Goals (SDGs) recognize that ensuring universal access to reproductive health (RH) information, services, and supplies, and integrating RH into universal health coverage (UHC) programs and strategies are critical to reducing global maternal mortality. This especially pertains to Goal 3, “Ensure Healthy Lives and Well-Being for All”¹ which is an important means for achieving other SDGs and emphasizes the need of ensuring universal health coverage including access to essential services and financial protection against medical impoverishment (Tangcharoensathien, 2015b). As countries move forward in pursuit of expanding coverage of RH services, they must ensure that the commodities required to deliver these services are available and affordable. Many countries have already begun these efforts and it is important to understand how FP/RH

¹ Targets 3.1, 3.7, and 3.8 of the Sustainable Development Goals. See: United Nations. *Transforming our world: the 2030 Agenda for Sustainable Development*. Resolution adopted by the General Assembly on 25 September 2015. http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/70/1&Lang=E (January 8, 2016).

commodities have been covered in existing UHC strategies and how supply chains have been affected as UHC schemes are rolled out so that other countries just embarking on these efforts can learn from past experiences. To this end, we undertook a systematic literature review looking for evidence of the effects of UHC schemes on access to RH/FP commodities and on supply systems. In order to conduct the review, we first needed to agree on a definition of key concepts such as UHC.

According to the World Health Organization (WHO), universal health coverage (UHC) is the goal that all people can obtain the prevention and treatment health services they need without suffering financial hardship when paying for them (WHO, 2010). Despite the momentum behind UHC, its precise meaning and implications for implementation are unclear (Bump, 2015; O'Connell, 2014). As national governments and partners translate UHC from an aspiration into actionable plans, they must ensure that the RH needs of women, young people, and other vulnerable and marginalized populations are fully addressed. Current debates on how exactly to do this are taking place led globally by UN agencies, governments and coalitions and at the national level by ministries of health and finance. By 2013, more than 70 countries had requested technical assistance from the WHO in implementing UHC and several networks such as the Social Health Protection Network (P4H) and the Joint Learning Network (JLN) had been created for that purpose (Brearley, 2013).² Although there is no widely available and agreed upon list of countries which have achieved UHC, according to the International Labour Organization (ILO), in 2014 about 100 countries moving toward UHC had more than 50 % of their populations covered (ILO, 2014). Stuckler's 2010 evaluation of 194 countries found that at least 58 have achieved UHC defined as fulfilling three indicators: UHC explicitly defined in the country's laws and policies; coverage of skilled attendance at birth is over 90%; and population covered with health care insurance greater than 90% (Stuckler, 2010).

As countries move forward in pursuit of UHC, their governments need to make difficult decisions regarding key questions: which services should be covered and why, who should be covered, and what cost will be covered and how. The WHO's UHC framework (WHO, 2008) that provides guidance to help answer those questions implies that countries obligated to move toward the ultimate goal, may do so in incremental and equitable steps, otherwise defined as "progressive universalism" (Jamison, 2013), rather than through a "big bang" approach (World Bank, 2011). Since changes will not automatically translate into improved access for the poor, nations must commit to include the least well-off from the very beginning of the process (Gwatkin, 2011). Countries such as Ethiopia, Kenya and Brazil have established supply-side schemes that channel resources to expand capacity of public health facilities to deliver free of charge services and interventions that target the poor. Demand-side financing mechanisms such as pro-poor health insurance that purchase specific services on their behalf are gaining momentum in other low- and middle-income countries such as Ghana, Indonesia, Philippines, Colombia, and Mexico (Cotlear, 2015; Tangcharoensathien, 2015b). Regardless of the strategy chosen, progress toward UHC is undeniably linked to the extent of risk-pooling, the commitment to implementing complementary equitable policies, and the strength of the overall health systems. Alkenbrack points out that many Latin American countries have relatively strong health systems paired with UHC programs that helped increase access for priority services such as family planning, ANC and facility-based care (Alkenbrack, 2015).

² See P4H and JLN websites at <http://p4h-network.net> and <http://www.jointlearningnetwork.org>

To achieve the SDG targets for UHC and reduce maternal mortality, countries must prioritize the core package of RH services and essential supplies. Family planning plays a critical role in realizing UHC. It is cost-effective for saving lives and averting more expensive health services. The principles of UHC and efforts to increase access to RH services share clear commonalities that support the argument to bring them together: both are grounded on key elements of rights, equity, and quality, and both require effective monitoring and accountability to ensure access to the right services and the right supplies, for the right people, and in the right place. Improved health equity for women and girls should be an explicit intent of UHC paired to legal and policy changes that provide a more enabling environment for them (Action for Global Health, 2013). However, marginalized women may fall through the cracks of insurance schemes for a number of reasons (Kowalski, 2013). Designing and implementing UHC programs that work for women and girls with the adequate provision of RH services is essential both for improving health outcomes and creating entry points for other important health services as seen in countries like Mexico, Thailand and Rwanda (Quick, 2014). The recent launch of the Global Financing Facility that is currently supporting financial transition in at least 12 countries also confirms the paramount importance of universal access to RH services for women and girls to achieve equitable societies by the year 2030 (GFF Working Group, 2014).

For countries implementing UHC programs defining health benefit packages is crucial since they are often confronted with competing priorities and finite resources. This may pose the potential risk of neglecting RH supplies, particularly contraceptives, or could be an opportunity for improving access and strengthening RH commodity security. However, just as there is no single best path to UHC, there is no silver bullet solution to ensure access to RH supplies (Yeager and Castaño, 2015). UHC programs such as social insurance have several entry points to help improve access to medicines and supplies and reduce out-of-pocket expenses. They can determine the medicines benefit packages; define and implement policies that improve cost-effective use of supplies; negotiate product prices and reimbursement lists; dictate standards of product quality; and strengthen supply chains and managing capacity. Still, there is scant evidence to support or refute these assumptions (Faden, 2011).

In an effort to contribute to documentation of these experiences, we undertook a systematic literature review looking for evidence of the effects of UHC schemes on access to RH/FP commodities and on supply systems. Our purpose was to identify lessons learned and recommendations regarding how supply chain systems have been adapted to increase availability, accessibility and affordability of reproductive health medicines and supplies. We anticipated that the review could provide an evidence base that could be used to advocate for best practices to governments, civil society and other stakeholders. The overarching question guiding our review was how do different strategies for achieving UHC affect access to medicines and commodities for family planning, reproductive health, and maternal health?

Methodology

We performed a comprehensive review of published peer-reviewed and grey literature to find evidence about the effects of UHC programs on availability to medicines and commodities for family planning, reproductive health, and maternal health and on supply systems in countries that are making progress towards UHC.

Before the study we did a preliminary non-structured search and collected anecdotal information about the lack of evidence and came across only one systematic review (Faden, 2011) about pharmaceutical policies implemented by health insurance systems and their impact on cost effective use of medicines in low- and middle-income countries. Our review was designed to include all UHC programs and related reforms, comprising demand-side (health insurance schemes) and supply-side programs, and their effects on reproductive health supplies. We were alerted that systematic reviews in public health share challenges in “making best use of the sometimes poor, often sparse and usually heterogeneous evidence available” (Petticrew, 2009).

We initially used the definition of universal health coverage shaped by the World Health Organization (WHO): “*universal health coverage (UHC) is the goal that all people can obtain the prevention and treatment health services they need without suffering financial hardship when paying for them*” (WHO, 2010). In operationalizing this definition for our review, we used a broad interpretation that includes both health sector reforms and supply- and demand-side country programs whose purpose is to attain universal health access with emphasis on the poor.³

We defined reproductive health supplies as any material or consumable needed to provide reproductive health (RH) services. This includes, but is not necessarily limited to maternal health medicines, contraceptives for family planning, and equipment such as that used for safe delivery.⁴ We excluded from our operational definition all drugs to treat sexually transmitted infections and included the three priority family planning commodities (emergency contraception, implants, and female condoms) and the three maternal health medicines (misoprostol, oxytocin and magnesium sulfate) prioritized by the United Nations Commission on Life-saving Commodities for Women and Children (About Life-Saving Commodities, n.d.).

We defined supply systems as the processes and procedures in place to ensure access to essential medicines and supplies, to promote their rational use, and ensure their quality, safety and efficacy. We included key system functions such as selection, procurement, distribution and utilization, and the enabling policy and legal framework in which the system operates (MSH, 2012).

We searched for publications related to low- and middle-income countries defined by the World Bank’s latest estimates of Gross National Income per capita (GNI) (Country and Lending Groups, 2016). We refrained from referring to the large body of literature from high-income countries much of which has relevant information about UHC, particularly on health insurance (e.g. USA, Japan, England, France, Germany, Chile).

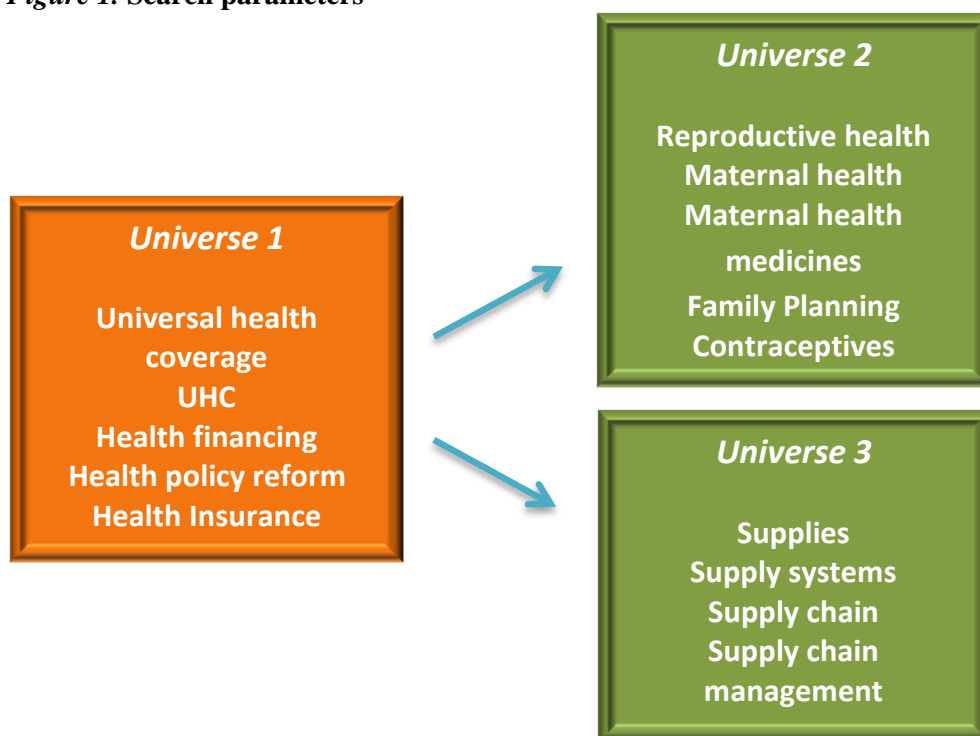
Using the parameters mentioned above we developed a list of key terms and conducted a search using these terms in four databases -- Pubmed, LILACS, Popline, and JSTOR. The key terms were grouped in three universes as illustrated below (Figure 1). Combinations used keywords from Universe 1 AND Universe 2 OR Universe 3. For instance, we use the term ‘universal health coverage’, OR ‘UHC’, OR ‘health insurance’ AND ‘reproductive health’, OR ‘family planning’, OR ‘supplies’, OR ‘supply chain’.

³ Taking into account the classification done by Cotlear et al.

⁴ See more at <http://www.thehealthcompass.org/project-examples/reproductive-health-supplies-country-profiles-website>

Additionally, we employed a “snowball” approach searching through reference lists of select articles (reference chaining) to ensure that secondary research and non-research articles of importance were included. We also conducted a companion search of grey literature, consisting largely of reports from working groups and organizations, editorials, commentaries, and blogs. For this, we used Google, and examined organization and project websites including: WHO, World Bank, UNFPA, USAID, UHC Forward, and the Rockefeller Foundation.

Figure 1. Search parameters



We formed an expert consultative group (ECG) to assist investigators develop inclusion criteria for the literature review, consider relevant areas of exploration and relevant research questions and sub-questions, and help track down information not published in peer-reviewed publications or located in grey literature via their extensive networks. The ECG consisted of RHSC members, programmers and researchers in UHC or RH/FP supplies.

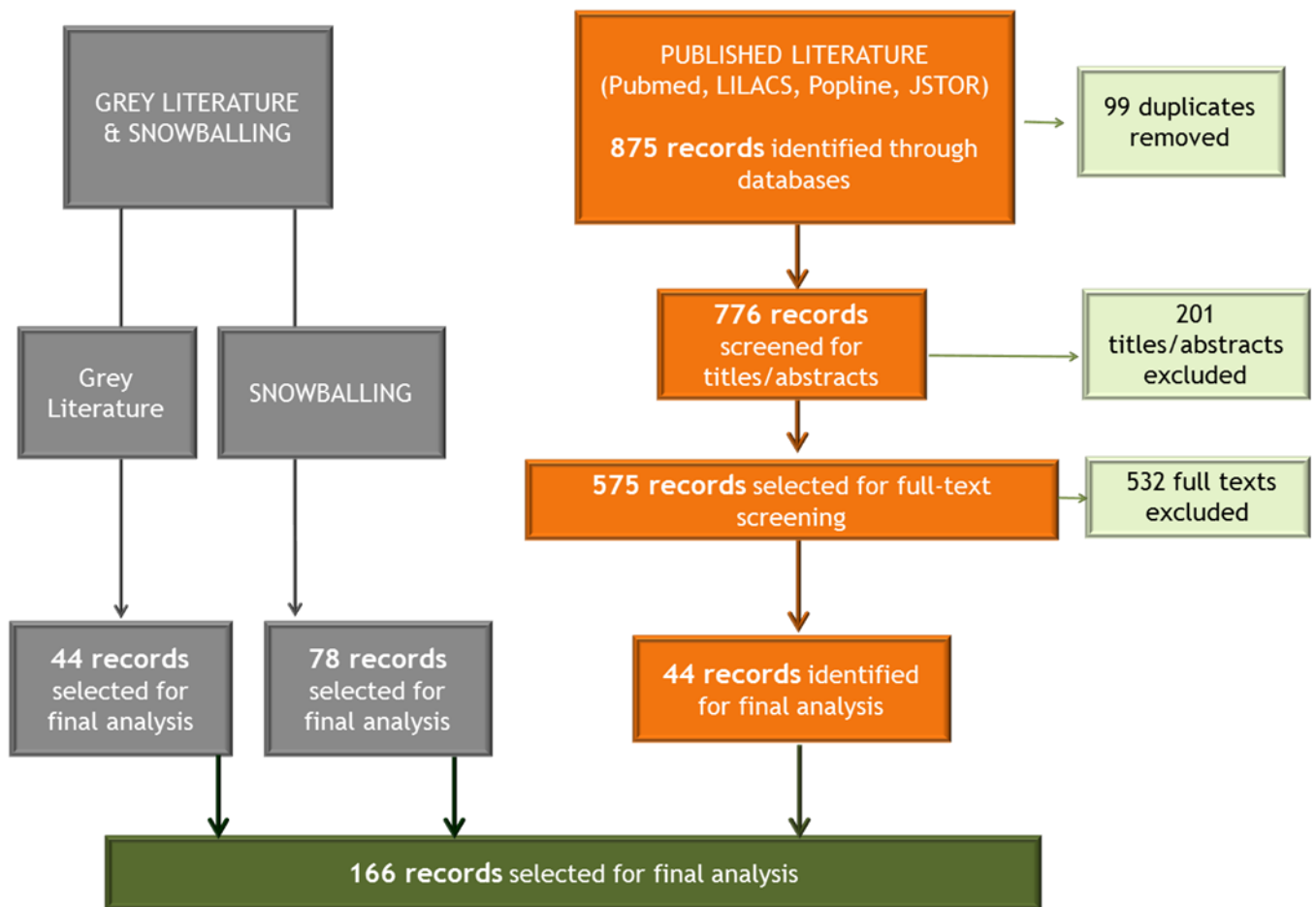
We limited the search to materials published after 1981 in English, Spanish, or French. Our review selection process is shown in Figure 2. Titles and abstracts of all the records were screened and those clearly irrelevant were removed. A full-text review was conducted for the remaining articles. Articles were included if they answered “yes” to the question: *Does the article directly address UHC and FP/RH/MH supplies or supply systems considerations?*

Articles were organized by country to facilitate analysis. A standardized, pretested form was used to extract information from the final selection of articles, including: details of UHC strategy by country, impact of the strategy on FP/RH/MH, how supplies were considered and affected by the UHC strategy, and general ramifications of the UHC on the health sector.

Results

Through the search of published literature 575 items were found that complied with the criteria of including key terms from search universes described in the methodology and were selected for full-text screening. From this, 44 records were identified for final analysis along with 78 additional publications cited in the search documents themselves (snowballing) and 44 more from reviewing grey literature. These one hundred sixty-six (166) publications met the criteria of containing any description of management of or policies related to reproductive health medicines and supplies in the context of a UHC strategy or intervention. From those, 68 were journal articles, and 91 were technical reports or briefs. The remaining documents included news item, blogs, presentations and website content.

Figure 2. Search strategy



Of the 166 publications, 36 described multiple countries, while 130 were focused on specific countries from Africa (e.g., Kenya, Ghana, and Uganda), Asia (e.g., Philippines, Bangladesh, and Thailand) and Latin America (e.g., Mexico, Colombia, Peru). The geographic distribution of the articles found is described in Table 1.

Table 1. Geographic distribution of publications

| Region | # of Publications |
|---------------------------------|-------------------|
| Asia | 47 |
| Africa | 68 |
| Latin America and the Caribbean | 14 |
| Europe | 1 |

UHC strategies included demand-side, supply-side and health sector reform initiatives. The demand-side UHC strategy most frequently described in the documents was national insurance. Other demand-side interventions included social insurance and interventions to reduce financial hardship (e.g., vouchers). Supply-side UHC strategies included health systems strengthening interventions and exemption of user fees. Finally, health sector reform initiatives as part of overarching UHC strategies were also described, such as decentralization. Many publications, particularly country case studies or status reports mentioned multiple interventions. (See Table 2)

Table 2. Types of UHC schemes or initiatives described in publications

| Type | Scheme/Initiative | Total # of Publications |
|-----------------------------|--|-------------------------|
| Demand-side | National Insurance | 54 |
| | Social Insurance | 4 |
| | Strategies to reduce financial hardship (incentives, conditional cash transfers, vouchers) | 6 |
| Supply-side | Health Systems Strengthening interventions | 18 |
| Health Sector Reform | Re-organization, decentralization | 13 |
| | Policies on user fees (institution, exemption or removal) | 21 |

** Note: many publications addressed several types of schemes or initiatives in describing country plans for achieving UHC.*

No Rigorous Studies Found on the Effects of UHC on Reproductive Health Supplies and Supply Systems

We found no rigorous studies on the impact or even effects of UHC strategies on access to reproductive health supplies, or documentation describing the effectiveness of interventions to strengthen supply systems in the context of UHC. While many publications commented on the problem of frequent stock-outs or lack of availability of reproductive health supplies, including both family planning methods and maternal health medicines and supplies, largely in the context of quality of services provided and the implication of increased out-of-pocket expenditure (e.g., Lang'at, 2015; Kumar, 2014; Honda, 2011; Pooley, 2008), none described the underlying causes of these stock-outs or the efforts undertaken to mitigate them. Furthermore, none of the publications reviewed explicitly described how implementation of the UHC strategy or scheme affected the supply system or how the supply system was adapted to respond to the increased demand generated by the UHC strategy- the overarching question this review sought to answer.

The publications did however contain some limited information on the five key management and policy areas that affect access to and use of medicines and supplies and have been used to frame more general studies of UHC and essential medicines (Faden, 2011):

1. Selection of commodities that schemes provide or subsidize
2. Strategies for procurement, supply and reimbursement
3. Contracting with or paying providers who prescribe and dispense
4. Commodity utilization management tools
5. Information systems for monitoring prices, prescribing behavior and user satisfaction.

Furthermore, since in most countries universal health coverage depends on a broader strategy that involves various health systems strengthening interventions, including provision of health services through the public sector, strong and resilient supply systems are critical. There is an ample body of literature that describes the challenges these systems face that are also applicable to reproductive health medicines and commodities (SIAPS, 2013). The key functions of supply systems presented above serve as an appropriate framework in which to present the results of this review.

Selection of reproductive health commodities

Reproductive health, including family planning and maternal health, figures prominently among the health services that have been and should be included in essential health packages (Singh, 2014). The definition of those packages and the medicines and supplies necessary to provide them is a critical step in the implementation of UHC strategies (Giedion, 2013; Faden, 2011). Countries may have a national policy that defines an essential package of services that all citizens should have access to. A national insurance scheme may either adopt that essential package of services in its entirety, or opt to cover a subset of the package. Social insurance schemes tend to be narrower in scope, and focus on services relevant to specific target populations such as women and children. Pro-poor policies or strategies to reduce financial barriers also often focus on an even narrower package, of priority services for specific vulnerable or underserved populations, at least in the initial stages of expanding coverage (Grainger, 2014, Cotler 2015).

A recent analysis of essential packages in 24 countries shows that reproductive health services, including family planning, and antenatal care, delivery and postnatal care are included to some extent in all essential packages. However, not all modern methods are included in the essential packages in all cases. Most notably male and female sterilization is inconsistently included in the essential packages. Antenatal care, delivery and postnatal care are also included in most packages, with most packages focused on primary and secondary levels of care (Wright, 2015a; Cotler, 2015).

None of the publications found provided descriptions of the decision-making process for inclusion of reproductive health benefits packages, such as who decides what goes into the benefits package, on what basis or how often it is reviewed. Descriptions of the aforementioned topics are widely available in more general terms in publications that overall development of UHC schemes (Giedion, 2013, Cotler 2015). Criteria commonly used to develop the benefits package include magnitude of the health issue, effectiveness of the proposed health interventions, capacity of the health-care system to resolve the issue with existing resources, and cost. Some countries have also social consensus as another criterion, fostering civil society participation in the process to define benefits packages (Missoni, 2010).

Related to the basic package of services, but specific to health commodities, national essential medicines lists are another critical element in defining what medicines and supplies are procured for use in the public sector, which is key when UHC strategies include pro-poor policies and insurance, or supply-side strengthening interventions. These lists may also serve as the basis for formularies or reimbursement lists specific to insurance schemes. While none of the articles found specifically addressed inclusion of reproductive health supplies in essential medicines list, the absence of key family planning commodities or maternal health medicines, particularly when these are new products or intended for new uses has been cited as a problem by the UN Commission on Life-Saving Commodities for Women and Children (ICEC, 2014; UNFPA, 2012a).

Similarly, none of the publications found contained information regarding strategies for selection of medicines and supplies for reproductive health such as the development of formularies or reimbursement lists that have been described more generally for essential medicines (Faden, 2011).

It is critical that the all of the various policy documents that are related to selection of reproductive health commodities (essential package of health services, essential medicines list, reimbursement lists, formularies, or even standard treatment guidelines and service delivery protocols) are harmonized thus creating an enabling policy environment for their procurement, distribution and use. The absence of harmonization among these policies can present a major obstacle to ensuring access (MSH, 2012; SIAPS, 2013).

Strategies for procurement and reimbursement

Medicines and commodities often represent a significant portion of expenditure on health, whether that expenditure is incurred by a national government when providing services to targeted segments of the population, or families who may or may not be covered by a UHC program (WHO, 2011). As such, as countries increase coverage both in terms of the number of reproductive health services provided through the essential package, as well as in terms of population covered, they must carefully consider strategies for the procurement and reimbursement of medicines and supplies for reproductive health in order to increase cost-efficiencies and reduce out-of-pocket expenses while ensuring access.

Depending on the level at which procurement occurs, and the scope, various strategies can be employed to reduce cost and assure quality. For example, at the national level bulk procurement, framework contracts or price negotiations with manufacturers have been proven effective in reducing prices. Similarly, for sub-national procurement in decentralized settings, these strategies have also been successful (Faden, 2011). In settings where facility-level or community-level procurement of commodities occurs, there has been mixed success with small capital strategies such as revolving funds (MSH, 2012, Chapter 13).

Our search yielded very few publications that mentioned how these strategies were employed specifically in the context of reproductive health supplies and UHC. Reports from the Philippines and India suggested that decentralization of procurement lead to stock-outs of reproductive health supplies, at least during the initial phases of the reform (Lakshminarayanan, 2003; Gupta 1999). Reports from Mexico and the Philippines showed similar negative effects of decentralization on access to reproductive health supplies (Knaul, 2012; World Bank, 2011). Reports from Bolivia and the Philippines recommended the establishment of community pharmacies with revolving drug funds for remote areas as an effective strategy to ensure access to commodities for maternal and child health, but presented no evidence to support this claim (Pooley, 2008; World Bank, 2011). No publications were found that provided an analysis of cost-effectiveness, cost-efficiency or increased availability due to implementation of a given procurement strategy.

For insurance schemes, a topic closely related to procurement is management of reimbursement of services or commodities. This may involve reimbursement from the insurance administration to a health facility or provider, or directly to the client. In either case, reimbursement for services or commodities provided presents challenges in even the most mature insurance programs. Not surprisingly, our search yielded descriptions of problems with reimbursement such as incomplete coverage of services and commodities provided, and delays in payment of reimbursement. Such problems can lead to increased out-of-pocket expenditures for clients and higher expenditures for health facilities (Lang'at, 2015).

Distribution, warehousing and inventory management

Distribution of health commodities, appropriate storage at various levels of the systems and proper inventory management of commodities are all important functions of supply systems. As countries progress towards UHC, these are critical areas that will need to be addressed to ensure availability of the commodities required for the provision of quality services. The many challenges to successful implementation of these functions have been well-documented for reproductive health supplies in general. Our search found no publications that described how these functions were approached or adapted in meet increases in coverage in the context of UHC (SIAPS, 2013).

Information systems for ensuring access to reproductive health supplies in the context of UHC

In order to measure progress towards the goal of UHC, and because pursuit of UHC is a dynamic, reiterative process, robust information systems that track service coverage, service utilization and financial data are key. As part of these information systems, data on availability and use of medicines and supplies are also critical. The UN Commission on Life-Saving Commodities has called attention to the lack of reliable data on many reproductive and most maternal health commodities (UNFPA, 2012b). Therefore it is not surprising that none of the publications found included a description of development or

adaptions in information systems for reproductive health supplies in the context of UHC. Only one publication, not specific to reproductive health, described a pilot experience of implementation of an open-source hospital information management system in Rwanda that tracked patient administration, medical record management and financial information (Karara, 2015).

Discussion

The purpose of this review was to examine the evidence around the intersection of universal health coverage and reproductive health supplies to determine what lessons have been learned by countries that have already advanced towards UHC and what recommendations can be shared with other countries as they move forward in planning for UHC. The paucity of publications found that measure, or even describe the effects of implementation of UHC strategies on supply chain systems for RH demonstrates the urgent need to analyze and document evidence on this topic from countries that have already moved forward in the process. The lack of information also indicates the need for the RH supplies community to continue to advocate for attention to and investment in supply chain systems strengthening to ensure access to commodities.

Proper planning for commodity management is often neglected although access to essential commodities is critical to the provision of quality services and the cost of medicines and supplies represents a large portion of health care expenditure and out-of-pocket cost for most people. Countries require a coordinated approach to strengthen supply systems for reproductive health and other essential health commodities to meet the increase in demand generated through the expansion of coverage in health services and to secure the availability and affordability of medicines and supplies through health providers. This coordinated approach needs to address the key functions of supply systems including selection, procurement, distribution, information systems, and governance.

In terms of selection, countries must employ an evidence-based approach to fine-tune the RH services and supplies included in benefits package under UHC. Likewise, policies related to medicines and supplies must be harmonized to ensure access. Regarding procurement and reimbursement, as stated above, commodities represent a major portion of health expenditure both for governments and individuals and as such every effort should be made to increase cost-efficiency and effectiveness while guaranteeing the safety and quality of the commodities. This requires improving the capacity of purchasers to utilize procurement strategies such as bulk procurement, and framework contracts, and to negotiate prices with manufacturers. In the case of insurance schemes, it also requires optimizing reimbursement processes and procedures to avoid stock-outs and increased out-of-pocket expenditure.

The search yielded very little information on distribution of reproductive health supplies within UHC strategies. Ensuring that medicines and supplies reach all the points where and when they are needed is a challenge in most countries. As countries increase coverage, particularly to vulnerable and hard-to-reach populations, distribution of essential commodities will prove to be an even great challenge. Countries will need to consider innovative strategies including public-private partnerships to address this challenge. Some of these strategies such as the community pharmacies in the Philippines or Bolivia mentioned above are worth exploring further. Another example includes the Accredited Drug Dispensing Outlets approach used in Tanzania (Minzi, 2013).

Similarly, despite the importance of robust information systems for measuring progress toward the goal of UHC and especially for tracking availability of essential commodities, we found very little documentation of information systems currently in use in countries pursuing UHC. Information systems to measure all aspects of access including product flow (availability), source (accessibility – if patients who are entitled to free or low cost products through benefits are purchasing products from third party providers), cost (affordability) and client perspectives and safety—pharmacovigilance, but also possibility of reporting issues with quality (acceptability) are essential. The lack of data on reproductive health supplies, including maternal health supplies was highlighted by the UN Commission on Life-Saving Commodities for Women and Children in its report from September 2012 (UNFPA, 2012b). Since the publication of the report, an effort to create dashboards on availability and other related issues are underway (RMNCH Strategy and Coordination Team, 2015). Similarly, the Reproductive Health Supplies Coalition created a suite of indicators that countries can use to measure access to reproductive health commodities. Indeed FP2020 has adopted one key indicator on stock-outs as part of the measurements FP2020 countries are asked to report on (RHSC, 2015). UHC programs must include indicators such as this that help measure their progress both improving service quality and reducing financial hardship for beneficiaries.

Finally, and perhaps most importantly, in order to ensure access to reproductive health commodities as a necessary step in achieving UHC, national governments must make difficult decisions regarding health priorities and finances. This requires that decisions-makers at all levels have the knowledge and skills necessary to make these decisions and implement them. It also requires that the stewardship and regulatory functions of ministries of health, ministries of finance and insurance administrators among others are strengthened and that authorities are held accountable. In order to foster accountability, beneficiaries of UHC strategies should be empowered to assert their right to services and supplies under UHC schemes.

Pursuit of the goal of universal health coverage requires a broad approach encompassing several strategies and schemes that should work together to ensure that the population, especially the poor and marginalized, has access to a package of services that addresses health needs at low financial risk. Reproductive health, including family planning and maternal health, figures prominently among the health services that have been and should be included in essential packages (Singh, 2014). These interventions have been shown to be efficacious and cost-effective in reducing maternal mortality and contributing to other positive health outcomes.

In conclusion, realization of the aspirational goal of universal health coverage implies strategic systems thinking and investment and requires strengthening the various functions of health systems and working with of all the people, institutions, resources, and activities whose primary purpose is to promote, restore, and maintain health (USAID, 2015). In order to achieve SDG3, and the specific targets related to universal access to reproductive health services and supplies, and universal health coverage, countries will need to focus more on supply systems strengthening. Documentation of the successes and failures of supply systems strengthening efforts are crucial so countries can make evidence-based decisions regarding interventions to implement in their own settings.

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